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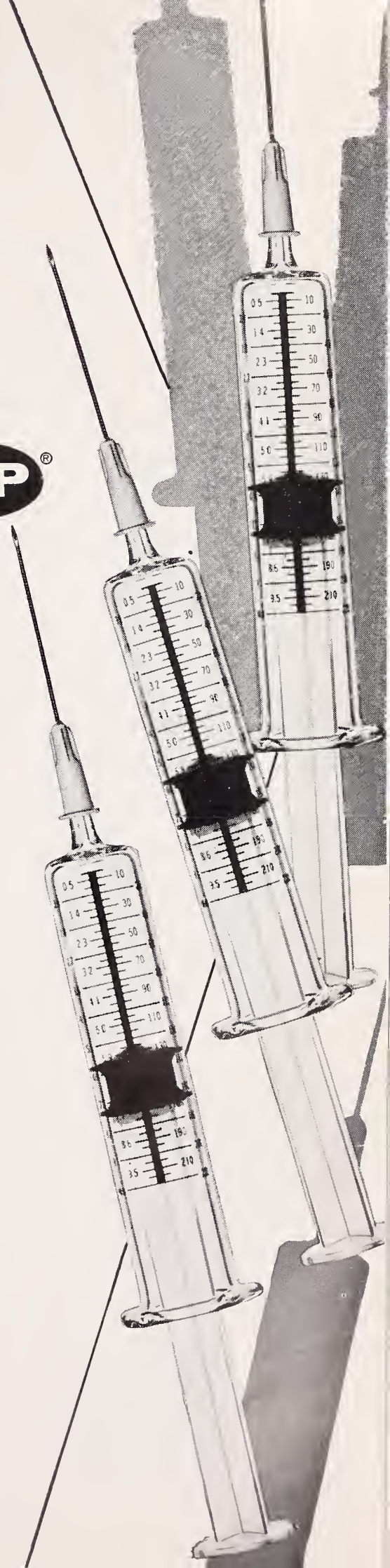
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Cover

This photomicrograph of a kidney (×400) was taken by Mr. Joe Jackson and the Department of Pathology, Emory University School of Medicine. Design by Mr. Ike Hussey, Higgins-McArthur, Longino & Porter, Co.

Patients in end-stage chronic renal failure, otherwise doomed to premature death, may have their lives prolonged and be rehabilitated by kidney transplantation.

Clinical Problems in Renal Transplantation

GARLAND D. PERDUE, JR., M.D., ROBERT B. SMITH, III, M.D.,
WILLIAM C. WATERS, III, M.D., E. GARLAND HERNDON, M.D., and
CHARLES C. CORLEY, M.D., *Atlanta*

DURING RECENT YEARS surgeons in this field have been able to compile data on hundreds of patients who have undergone transplantation of a kidney, and many of these patients have been restored to a state of health which permits them their normal activities.¹⁻³ This is not to imply, however, that this procedure has been made routine or that complex problems in achieving these results do not exist.

Careful Patient Selection

Since the patient with chronic renal failure who is a potential recipient is inevitably seriously ill, it is essential that careful patient selection be emphasized as the first problem. Severe uremic manifestations may be partially corrected by repeated dialyses, anemia by transfusions, and hypertension by appropriate therapy.

It is important to note, however, that the potential recipient must not have suffered irreversible damage to any other major organ system if renal transplantation is to offer restoration to useful life. Those patients, then, with advanced degrees of anatomic heart disease, associated arteriosclerosis, and central nervous system damage must be ex-

cluded. Patients of advancing age often may fall into one of these categories; and even if they do not, their potential for rehabilitation must be regarded as limited. In such instances, persistence in palliative medical therapy, including repeated or chronic dialysis, should in most instances be regarded as a more desirable alternative.

Suitable Donor

Finding a suitable donor for the patient who is an acceptable recipient is the second problem that requires major emphasis. Major blood groups must be compatible, and the results from most centers have been best when a living related donor could be selected. Such a donor must be in good health, have two normal kidneys, and be willing to volunteer donation of one of his kidneys with full understanding of the hazards involved.

While a death in a donor from removal of a donated kidney has not yet been reported, this possibility must be contemplated, and the patient must be aware of this risk, no matter how slight. Further, he must fully understand the potential morbidity which, at the least, includes a major surgical procedure with its risk of complications and delayed recovery, as well as the period of convalescence that will keep him away from home, work, and

Presented before the Surgery Section Meeting, 114th Annual Session of the Medical Association of Georgia, Augusta, May 6, 1968.

other responsibilities for a period of time. He must be understanding also of the psychologic impact should the transplant fail and his sacrifice go for naught.

Kidneys From Cadavers

Because such donors are simply not available in many instances of need, attention has been directed for years to the possibility of obtaining kidneys from cadaver donors. The use of a cadaver donor requires sympathetic understanding on the part of the decedent's family and their willingness to give permission for this to be done.

Since irreversible tissue damage begins to occur shortly after death, it is necessary to obtain such permission immediately and rapidly assemble the team of professional and paramedical personnel who will be involved in retrieving the donor kidney and transplanting it into the recipient.

The recipient must be prepared and readily available for immediate surgery, and the kidney must be retrieved from the cadaver donor and implanted into the recipient with aseptic surgical technique and within a period of a very few hours. Even so, some degree of tubular damage is usual, and such a kidney may not function adequately in the recipient for several days or weeks. Thus the recipient may require continued treatment for a period of time beyond his surgery until the transplant kidney begins to function adequately.

Complex Technical Procedure

The technical procedure of kidney transplanta-

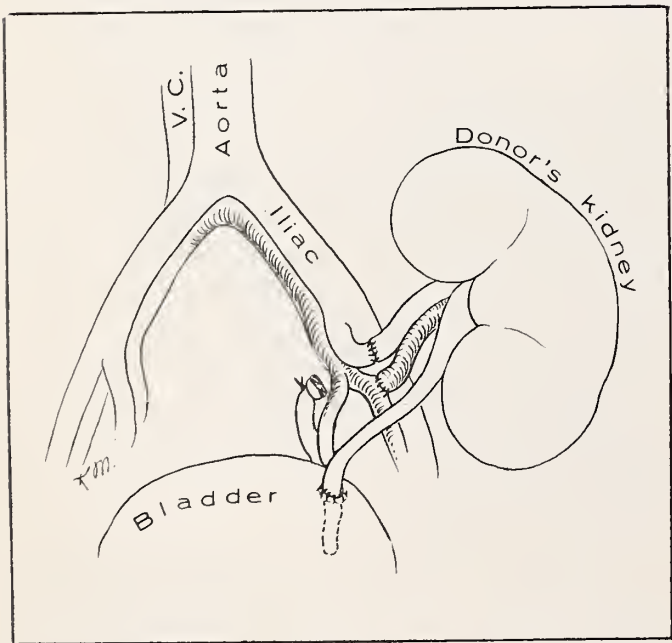


FIGURE 1

Sketch illustrating transplant kidney after completion of anastomoses.

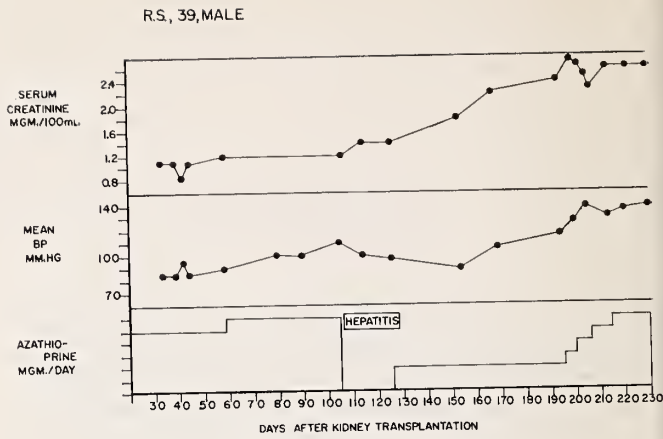


FIGURE 2

Effect on renal function of withdrawal of azathioprine during episode of serum hepatitis.

tion is itself sufficiently complex to create potential problems (Fig. 1). First, a team of skillful and experienced surgeons should be available, some members removing the donor kidney while others prepare the recipient for transplantation. Arterial and venous anastomoses must be performed expeditiously but with care to ensure continued patency.

Similarly, ureteroneocystostomy must be performed with care to prevent technical complications of excessive reflux, ischemic necrosis of distal ureter, or scar formation with stricture and partial ureteral obstruction with hydronephrosis. Since the bladder is opened and since there may be drainage of urine from the reimplanted ureter into the bladder, the operative wound is potentially contaminated, and postoperative complications in the wound, as well as those related to these vital anastomoses, may make the transplant ineffective.

Preventing Rejection

That these problems are surmountable is indicated by the fact that the procedure is now being done in many large medical centers. The most difficult problem remains the prevention of immunologic rejection of the transplant organ. As implied above, when a living related donor is available, such a donor is best. It is essential that major blood groups be compatible.

Much interest has been generated in efforts to type and match tissues.⁴ While some success has been achieved, such techniques are as yet by no means perfect, and lack of a match by present techniques does not preclude a successful transplant. On the other hand, an apparent match gives no assurance that a vigorous rejection cannot occur.

Emphasis on Drug Therapy

In spite of hope for improved tissue typing and

matching techniques, reliance must presently be placed on drug therapy to suppress (although not completely eliminate) the immune response.⁵ Such drugs include azathioprine, prednisone, and, more recently, antilymphocyte globulin obtained from the serum of horses immunized to human lymphocytes.⁶ While whole-body irradiation is no longer advocated, local irradiation to the transplant is thought to inhibit the acute cellular response which sometimes results in early rejection.

Comprehensive Follow-Up

Follow-up on transplantations requires frequent interviews, examinations, and testing. In addition to the patient's well-being and physical appearance, the weight and blood pressure are recorded and the urine examined for protein excretion. An effort is made to keep the white blood cell count just above leukopenic levels. The hemoglobin and hematocrit are often low normal or at slightly anemic levels. The platelets are at normal levels. Excessive depression of any of these parameters may indicate the need for reduction of azathioprine. Renal function is measured by determinations of the BUN and the serum creatinine, with occasional measurements of the creatinine clearance.

Recognizing Rejection

Manifestations of rejection should be recognized early, before the onset of such advanced phenomena as fever, pain from the swollen kidney, and progressive oliguria. Thus the onset or increase in amount of protein excretion in the urine and rise in the blood pressure should be heeded as warnings. Rises in the BUN and serum creatinine, with corresponding decrease in creatinine clearance, indicate an exacerbation of the rejection response. Frequently these can be reversed quickly by increasing the dosage of prednisone and azathioprine,

and often the addition of 150 r local irradiation to the transplant.

The importance of the immunosuppressant drugs is illustrated in Figure 2. This patient had done well after transplantation until serum hepatitis necessitated withdrawal of azathioprine. The decline in renal function indicates the rejection response that occurred, and the stabilization of renal function is noted when azathioprine is resumed in adequate dosage.

Repeated Rejection Crises

The severely acute rejection reaction is manifest not only by inadequate and decreasing renal function but also by fever, pain, oliguria, and—if it occurs in the early postoperative period—the development of intravascular thromboses and patchy areas of infarction of renal tissue. Most patients, however, tend to show intermittent, repeated episodes of rejection crisis. If these crises are mild and readily controlled, acceptable renal function may be preserved for an indefinite period of time.

In general those transplant kidneys which have maintained an acceptable level of renal function for one year or longer are expected to function indefinitely, with infrequent exceptions. Some patients develop histologic changes in the kidney thought to represent chronic rejection, and these changes may be associated with a progressive decline in renal function without episodic characteristics (Fig. 3).

Results of 20 Transplants

The results of 20 transplants are indicated in Table I. Of 12 patients who received a kidney from a living, related donor, seven are alive with adequate kidney function, and no indication of progressive rejection, for periods of time ranging from six months to six years. One patient died postoperatively due to massive cerebral edema following a hypertensive crisis. A second patient died three months after transplant due to agranulocytosis and septicemia. One patient rejected the transplant acutely, and two additional patients had chronic rejection, resulting in eventual loss of the kidney. Of the three who rejected the transplant, two are being maintained on chronic dialysis and may receive a second transplant. The third did receive a second transplant but rejected it acutely and died of renal failure.

Results With Cadaver Donors

Eight transplants were from cadaver donors. Three patients maintained good renal function but three have died. One of the patients referred to

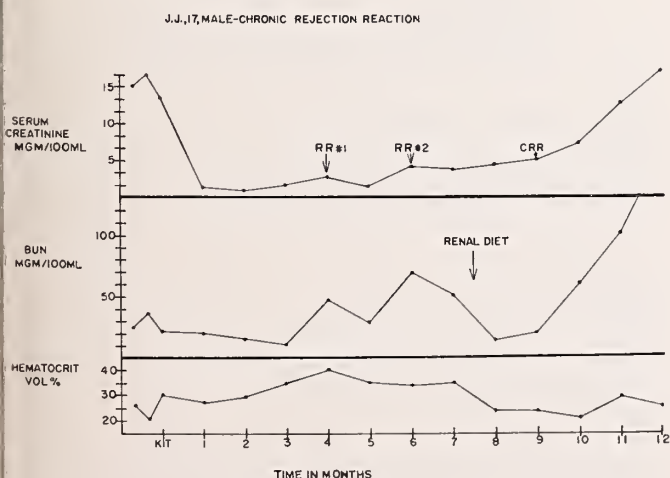


FIGURE 3

The development of chronic rejection and ultimate loss of kidney function.

CLINICAL PROBLEMS / Perdue et al.

above died after rejection of the transplant due to renal failure. Two other patients died at four months and 15 months, respectively, with functioning kidneys. Death was due to a ruptured congenital aneurysm in the transplant kidney in one patient and to disseminated histoplasmosis in the other. Another patient who rejected the cadaver transplant accepted a transplant from a living related donor and remains well; and a second patient who rejected a cadaver transplant received a second cadaver transplant and remains well.

Summary

Many problems remain in the successful transplantation of the kidney in treatment of end-stage renal failure. Reported results indicate, however,

TABLE I				
RESULTS IN RENAL TRANSPLANTATION				
	Number	Death	Rejected	Functioning
Living donors	12	2	3	7
Cadaver donors ..	8	3	2	3
Totals	20	5	5	10

CURRICULUM CHANGES OFFER MORE FREEDOM

Emory University medical students will have greater individual freedom in selecting their courses of study under new curriculum changes approved recently by the Advisory Faculty Council of the Emory School of Medicine. The elective opportunities will be offered largely in the senior year.

Effective in August

Dean Arthur P. Richardson of the medical school said the new curriculum will go into effect in August 1969, but implementation will come step by step. Students will thus have ample opportunity to plan their elective program for the senior year in 1970-71.

"Essentially these changes provide for increased flexibility in the training of physicians and will greatly increase the student electives," Dr. Richardson said.

During his senior year, the student will be able to spend 50 per cent of his time in a faculty-approved educational program of his own choosing, the dean explained.

Follow Proposed Guidelines

The changes follow guidelines proposed by the medical school's Advisory Faculty Council more than two years ago; they are also in keeping with recommendations adopted by the Association of American Medical Colleges at a meeting in Houston, Tex., early in November.

that a successful transplant can be accomplished; that the immune response can be suppressed; and that many patients may survive and resume a useful life for an indefinite period of time.

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Department of Surgery
Emory University

The AAMC urged that medical schools "individualize the education of the physician to fit the students' varying rates of achievement, various educational backgrounds and differing career goals."

AMERICAN COLLEGE OF
SURGEONS INDUCTS
GEORGIA PHYSICIANS

The American College of Surgeons has announced that the following surgeons from Georgia have been inducted as Fellows of the College:

Warren F. Brown, Robert B. Smith, III, and Walter B. Wildstein, all of Atlanta; Harry C. Sherman of Augusta; Franklin J. Star and Robert E. Talley of Columbus; Roy H. Crispin of Decatur; Floyd R. Cooper, Jr. and Gerardo J. Soracco of East Point; Werner A. Linz of LaGrange; Charles G. Magnan, Jr. and Alpheus M. Phillips, Jr. of Macon; Joseph C. Barnett, Jr., Spencer G. Mullins, Jr., Paul J. Payne and Thomas O. Sturkie of Marietta; Ralph M. Howse of Rome; Virgle W. McEver, Jr. of Warner Robins; and Edward B. Brown of Waycross.

The ceremonies took place during the annual five-day Clinical Congress of the College held in October.

Laboratory Problems in Renal Transplantation

ARTHUR L. HUMPHRIES, JR., M.D., ANN M. COFER, M.T.,
PHILIP A. WILLIAMS, B.S., and W. THOMAS VERNON, Augusta

KIDNEYS HAVE BEEN TRANSPLANTED into more than 2,000 patients. The surgical technique itself is not as difficult as many other surgical operations. But the physician must dialyze the patient many times preoperatively, must choose a suitable kidney, and must treat the patient postoperatively with potentially lethal drugs to minimize the rejection phenomenon. The physician must use the laboratory extensively for the usual laboratory studies, including careful antibiotic sensitivity studies, but also must use it for two unusual procedures—lymphocyte typing of the donor and recipient and, if a cadaver kidney is used, preservation of the kidney to be transplanted. This paper will describe in some detail techniques for typing and for preserving.

Compatible Antigens

In selecting a donor for a kidney transplant, it is best to select the one who will evoke the least response from the recipient; that is, the donor whose antigen make-up is most like that of the recipient. The proof of this statement lies in the universal observation that kidneys from close relatives have a better chance of surviving than do kidneys from unrelated persons.

Further proof has come from retrospective study of patients who were matched with their donors either prospectively or retrospectively. In one study

of patients tested a year after transplantation, of 18 *incompatible* recipients, 44 per cent had rejected their renal transplant or showed evidence of failing renal function, whereas of 32 *compatible* recipients only 9 per cent had done so. In another study there was correlation between the quality of matching and the quality of the homograft when biopsied two years after transplantation.

Despite such findings it must be emphasized that some recipients with kidneys from mismatched donors have fared well. Furthermore, most recipients have only one available donor and so have no choice. In one series of 20 patients, 17 had only one suitable donor available, so that the test was of academic interest only for them.

Matching Is Not Imperative

Thus, matching of donor and recipient is not imperative. In fact, it was done prospectively in few centers until very recently, and is still not done in most centers before transplantation of cadaver organs. It is being done more and more before transplantation of organs from live donors. And, of course, preservation of kidneys is not imperative; that is, other than reasonably quick removal of the kidney from the cadaver, followed by a flush with a cooled solution (a kidney can be preserved for 4 to 12 hours by simply being cooled).

Evaluating Donor and Recipient

Fortunately, most "transplantation" antigens are present on the donor's white blood cells which can be used, therefore, to represent the donor. However, the donor's cells cannot be typed by simply mix-

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ing them with serum from the recipient, because the recipient's blood serum will not usually contain enough antibodies to the donor's white blood cells to agglutinate them (no normally occurring isoagglutinins). But the donor's cells can be typed by mixing them with certain special sera, e.g. sera from women who have had many pregnancies or abortions will sometimes contain enough antibodies to make an agglutination test, or a cytotoxicity test, possible. So at present, the way to evaluate donor and recipient is first to set up the donor's lymphocytes against a battery of sera known to contain high antibody titers to get a measure of the antigens they contain, and then to set up the *recipient's* lymphocytes against the very same battery of sera to get a measure of its antigens. For a donor to be a "good match" he should not have *any* antigen that the recipient does not have.

Mono-Specific Sera

The tests for determining compatibility between donor and recipient have been developed in several laboratories around the world—Paris, Holland, Italy, Los Angeles, Palo Alto, and Durham. These laboratories use sera which have either been tested and found to be reasonably monospecific or which have been made monospecific by absorption; that is, they approach the ideal situation of containing one antibody against one antigen. Furthermore, these laboratories now have a fairly good idea of which sera, and thus which donor antigens, are important and which are not. They had to find out the hard way usually, by observing which antigens were present in the donor of a kidney which, when transplanted, failed to function well. It must be remembered that before transfusing blood, one generally need match only the three major antigens (A, B, and Rho) even though there may be numerous other "minor" antigens that do not match between donor and recipient.

A and B Antigens Must Match

This is a good time to emphasize that for best transplantation results the A and B antigens present on red cells must be the same in donor and recipient (or at least acceptable by transfusion criteria—O is the universal donor, etc.).

It is now thought that the immune reaction is governed by intermediate strength antigens, the number of which cannot yet be determined. There are, however, 12 antigen groups which have been reasonably defined so far.

Limited Supply of Antisera

Unfortunately, the laboratories studying matching techniques have only limited supplies of such antisera, since the antisera still have to be made from human subjects and as yet have not been made from horses or other animals. (Each test requires only a micro-drop or so of serum, but even so, no one laboratory can provide enough for the others.) Nor has any commercial company yet been able to provide such sera.

What a smaller laboratory must do, therefore, is to find its own antisera by separately screening the sera from many multiparous women. Each serum is tested against the lymphocytes of 20 to 30 "professional" donors, since it is fairly certain that among such a large donor population, the twelve major groups of transplantation antigens will be present. Some women who have had 5 or 6 pregnancies will have high antibody titers as a result of having been sensitized by the fetus to produce antibodies to fetal antigens inherited from the father. Some sera react too weakly to be of much value while others may be very strong but have multiple specificities. Moderate-reacting sera are frequently best for testing.

There is another way of getting antisera of greater specificity; antisera can be made by repeatedly injecting leukocyte suspensions into volunteers over a period of time or by actually grafting skin from one volunteer to another several times. But, of course, this way introduces some risk (probably minor) and considerable inconvenience to the persons involved.

Unfortunately, after several persons with suitable sera are found, there is no way to know if the several antisera are different from each other. With poor luck many women with high antibody titers might have high titers against the same antigen. For this reason, samples of sera should be sent to one of the large laboratories to be compared to one of the more well-defined sera. Then if a serum of unknown specificity correlates well with one of known specificity, it can be used in place of that certain serum.

Preserving Cadaver Kidneys

The second way that the "laboratory" must support the transplant program is that some part of the "laboratory" or team must be able to maintain the cadaver kidneys viable long enough—4 to 10 hours—to permit the lymphocyte typing, and long enough to prepare the one or two persons for operation, even if they are away from the hospital.

Heart-Lung Bypass

Kidneys can be preserved by use of heart-lung

bypass; this method has yielded exceptionally good kidneys in those situations when it is already in use—for an open-heart operation in which the heart cannot be resuscitated. And, heart-lung bypass, or some mechanical support of the circulation and respiration, even external cardiac massage, will preserve kidneys and other organs for short periods. In fact, these are methods that have been used to make possible the recent heart transplants. But such methods require a frantic use of two or three operating teams, frequently in the middle of the night, and make deliberate lymphocyte typing difficult at best. (Of course, it must be admitted that there are troubles enough getting one suitable donor for heart transplant at the right time.) Ideally though, it would be desirable to be able to preserve organs for six, 12, or 24 hours or more.

Perfusing Kidneys

So far there are two main ways to preserve organs. Both depend upon hypothermia to slow down metabolism in the organ. In 1964 we at the Medical College of Georgia reported that dog kidneys had been preserved well enough for 24 hours by perfusion of diluted blood at 10°C that they maintained life even when reimplanted and tested by immediate contralateral nephrectomy. By 1967 we had perfused one kidney with diluted plasma for five days; it maintained life when reimplanted and tested by delayed contralateral nephrectomy.

Recently, Belzer and associates using this method have achieved even better results. They used a slightly different perfusate—whole plasma with its labile lipoproteins filtered out and with certain drugs, including cortisone, added in. They reimplanted six consecutive dog kidneys that had been perfused for three days; even after immediate contralateral nephrectomy, the kidneys reverted the blood urea nitrogen level to normal or near normal within several weeks. Belzer has used the method to transplant successfully a human cadaver kidney after 17 hours' storage.

Using Hyperbaric Oxygen

In 1964, Manax and Lillehei introduced the other major means of organ preservation—hyperbaric oxygen. They successfully preserved kidneys for 24 hours at 4°C by placing them in a tank with oxygen under 30 pounds per square inch pressure. The mechanism of action is unknown to this day; nitrogen and helium under pressure work almost as well.

Combining Procedures

In 1966, Ackerman and Barnard combined the two methods; that is, they used a constant perfu-

sion, just a trickle actually, in a pressure tank, and preserved kidneys better than they had been able to with pressure alone.

Recently Starzl and associates have adopted this combined method to preserve livers and have had outstanding success preserving human livers for up to six or eight hours. Of nine patients, three are still alive, one now well after nine months.

Restoring Organs

Hopefully, organ preservation methods will improve to the point that the organs will not only be preserved but even *restored* toward normal. Even with present imperfect methods the organ deteriorates more in the dying body and in the dead body than it does in the preservation chamber. Actually this restoration has already been observed—at least in the case of “live” storage of organs, that is, temporary implantation of a dog heart or kidney in an intermediate dog. Hopefully human organs can be restored while residing temporarily in a primate, a baboon or chimpanzee. Conceivably the primate can be used eventually as a donor, which will thereby solve completely the problem of preserving organs.

ACKNOWLEDGMENT

The authors thank Dr. Paul I. Terasaki, Los Angeles, for the techniques involved in lymphocyte typing.

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SMITH KLINE & FRENCH FOUNDATION ISSUES ANNUAL REPORT

Total contributions by the Smith Kline & French Foundation to charitable, educational, scientific and community purposes have passed the \$100 million figure, it was revealed in the Foundation's 1967 annual report.

Contributions for 1967 were \$909,791, third highest annual total since the Foundation, established by Smith Kline & French Laboratories of Philadelphia, began granting funds in 1953 with contributions totaling \$236,900.

During its 15 years of operation, the Foundation has grown in breadth of interest as well as in volume of financial contributions. Its principal interest, however, remains medicine and the sciences related to medicine.

The author's experience in the treatment of more than fifty feet is discussed.

Surgery of the Foot

in Rheumatoid Arthritis

F. JAMES FUNK, JR., M.D., *Atlanta*

RHEUMATOID ARTHRITIS is a disease of unknown etiology characterized initially by inflammation of the synovium which progresses to involve the articular cartilage and the surrounding soft tissues, often ending in joint destruction. In the foot, the major involvement is in the forefoot and is usually characterized by lateral deviation of the great toe, resulting in a bunion deformity. Commonly there is also lateral deviation of the other four toes with a cock up deformity that may result in dislocation of the metatarsal joints.

As these deformities increase the forefoot broadens, the metatarsal heads drop down into the sole of the foot, and the clawed toes develop callouses

where they contact the top of the shoe. Wearing of shoes becomes progressively more difficult. Characteristically the midfoot and hindfoot are often spared until late in the disease. When it is involved, the subtalar joint is the chief victim and the result is a stiff foot with an exaggerated flatfoot deformity.

Forefoot Cannot Bear Weight

As the deformity progresses the patient becomes unable to bear weight on the forefoot. The cocked up toes frequently fail to make contact with the floor and the depressed metatarsal heads form cal-



FIGURE 1

This is a forty-year-old filling station owner scarcely able to walk because of progressive foot deformity.



FIGURE 2

Plantar view shows marked deformity of toes. Callouses beneath the metatarsal heads demonstrate the toes do not participate in weight bearing.

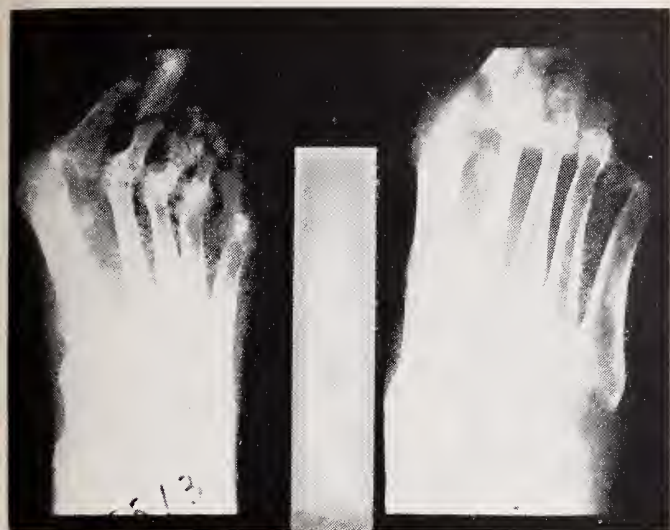


FIGURE 3

X-rays of same patient showing dislocation of all the toes at the metatarsophalangeal joints.

louses or even ulcerations on the sole of the foot. The patient has the impression that he is "walking on marbles."

In the initial stages properly accommodating shoes, supplemented with appropriately placed felt pads, metatarsal bars, and other standard corrections may be helpful. Home remedies often consist of slitting the shoes or wearing carpet slippers. Another solution is a special made shoe commonly called "space shoes" which are individually made from a plaster impression of the foot. These expensive box-like shoes are usually so conspicuous that most patients decline to wear them.

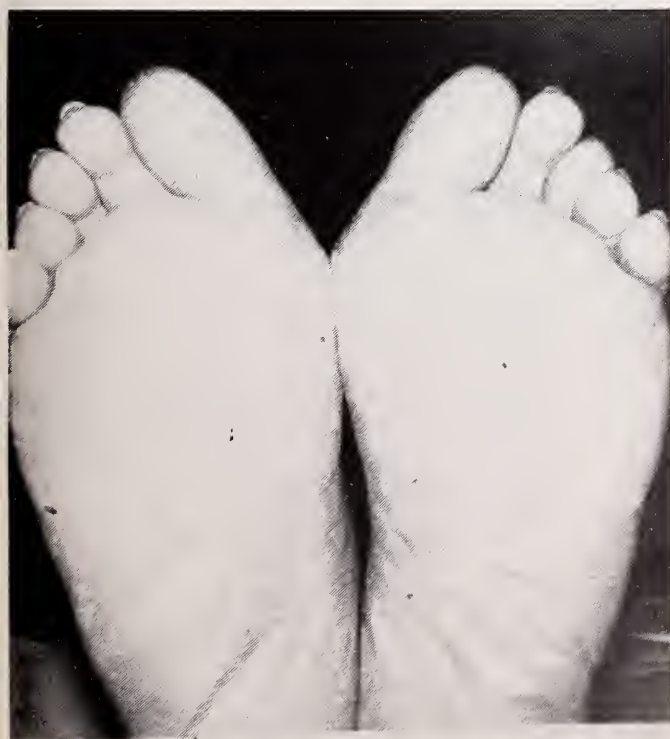


FIGURE 4

Post-operatively following MP joint resection toes are now down in normal position. Callouses are disappearing.

Indications for Surgery

Thus the deformities themselves are painful not only because of the inflammatory changes, but also because of the mechanical derangement of foot function. The chief indication for surgery is painful deformities despite conservative treatment. In the past some have felt that rheumatoid arthritis in itself was a contraindication to surgery. The belief that these patients have "suffered enough" or that surgical incisions are slow to heal has deterred many handicapped people from seeking relief through surgical correction.

Hoffman's Technique

In 1911 Hoffman¹ reported an operation for "severe grades of contracted or clawed toes." He felt that some of these cases consisted of what he termed "infectious arthritis." His technique was to resect all of the metatarsal heads through a single plantar incision. Others such as Thompson³ and Key² have advocated corrective surgery for the painful rheumatoid foot, but it remained for Clayton⁴ to popularize the MP joint resection for rheumatoid deformities.

Resection Arthroplasty

The essential treatment of most forefoot deformities consists of a resection arthroplasty of the metatarsophalangeal joints sufficient to remove the painfully depressed metatarsal heads and to allow correction of the bunion. At the same time, fol-

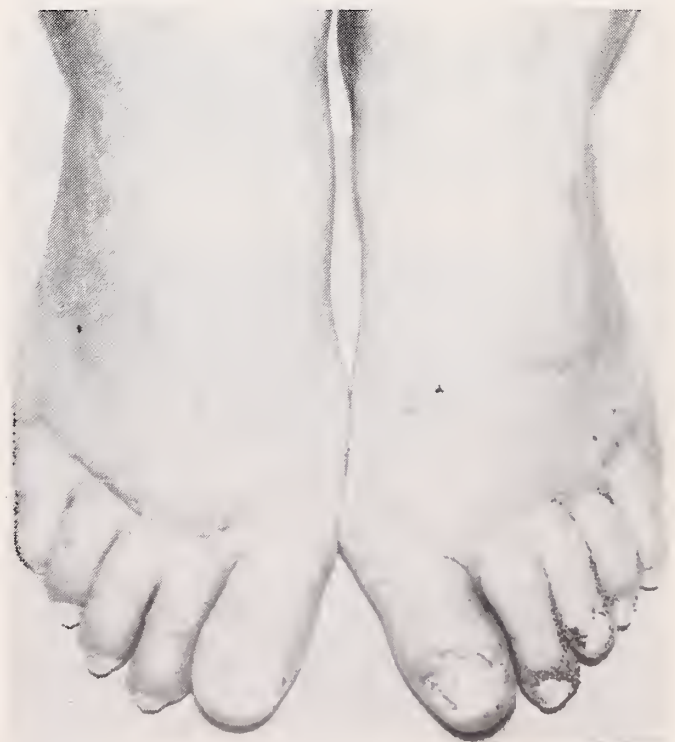


FIGURE 5

Same feet from Figure 4. On the right foot, the scar is still visible showing the line of incision across the base of the toes.

ARTHRITIS / Funk

lowing the joint resection, the hammertoe deformities of the interphalangeal joints can usually be corrected by manipulation. Too often in the past surgery has consisted of an attack on one or two of the toes that are the worst offenders. In severe deformities of the forefoot, the present trend is to resect all of the metatarsophalangeal joints enabling



FIGURE 6

Fifty-year-old lady with progressive toe deformity. Toes cocked up do not participate in weight bearing.

the deviated toes to be realigned. This is usually done through one incision, and when indicated both feet are done at the same operation.

Method

A single transverse incision is made across the dorsum of the foot just posterior to the toes. It may include the extensor tendon. The toes can then be depressed plantarward and the metatarsal heads



FIGURE 7

Same feet seen from the bottom. Note ulceration beneath protruding metatarsal heads.



FIGURE 8

Same feet post-operatively. Toes now aligned approximate the floor.

elevated and resected. Usually it is easiest to begin with the second toe and then proceed next to the big toe and finally to the lateral three toes. In each case following resection of the metatarsal head the undersurface of the neck is beveled to remove any sharp or irregular bony projection. When the deformity is severe it is usually advisable to resect the base of the proximal phalanx in the four medial toes.

Following the bony resection, hammertoe deformities of the interphalangeal joints are manipulated



FIGURE 9

Same feet from the bottom. Note absence of callouses and soft skin beneath metatarsal heads.

straight. The toes can then be shifted so as to align them properly with the forefoot and the wound closed. A bulky soft dressing is applied to hold the toes in a normal alignment and is changed on the second or third postoperative day. Thereafter the toes are well protected by a bulky dressing until two weeks have elapsed. During this time the patient is encouraged to walk as necessary with most of the weight on the heels in large loose bedroom shoes.

Rapid Healing

Contrary to common belief these feet heal rapidly

and promptly when the tissues are handled with care. Some thickening or swelling of the feet usually persists for several weeks and shoe fitting following surgery is usually deferred for several weeks until the post-operative edema has had time to subside.

To date, more than fifty feet have been operated on and it is the author's experience that this is usually a very satisfactory procedure, probably the best of the many surgical treatments devised for the rheumatoid patient. With the absence of the painful met-

atarsal heads, these patients develop a better gait and are able to push off effectively with the forefoot. Often when gait has improved, complaints referable to knees and hips are decreased.

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GRMP SPONSORS CLINICAL TRAINING CONFERENCES

Special postgraduate clinical training conferences in new methods of treatment for patients with heart disease, stroke and related diseases are now being offered to all practicing physicians in Georgia by the two medical schools through a cooperative arrangement with the Georgia Regional Medical Program.

Through this program, physicians from throughout the State will be given an opportunity to return periodically to a teaching institution to participate in new types of educational activity. Special clinical training will also provide new skills in diagnosis and treatment and bring the latest results of research in cardiovascular diseases to patients as rapidly as possible. Physicians will actively participate in the management of patients under the supervision of the medical school faculty.

Courses at Emory

Five courses will be offered by the Emory University School of Medicine, in Atlanta, beginning in January, 1969. These are:

- General Cardiology;
- Management of Coronary Care Units and New Approaches to the Treatment of Myocardial Infarction and Its Complications;
- Hypertension and Renal Disease;
- Cerebral Vascular Disease: Diagnosis, Treatment and Rehabilitation;
- Advanced Electrocardiography.

Each course will be given one day a week for 12 weeks—two to four times a year—with up to four trainees accepted per course. Starting dates will be flexible to fit physicians' schedules.

Faculty will include: Bernard L. Hallman, M.D., J. Willis Hurst, M.D., Elbert Tuttle, M.D. and Herbert Karp, M.D.

Courses at Medical College of Georgia

Four courses will be offered by the Medical College of Georgia, Augusta, also beginning in January, 1969.

- Coronary Artery Disease;
- Clinical Cardiology and Electrocardiography;
- Pediatric Cardiology;
- Techniques of Cerebral and Cardiovascular Angiography.

Courses 1 and 2 will be offered one day a week for 12 weeks—three times a year—with a maximum of four students per course; course 3 will be offered one day a week for six weeks—four times a year—with a maximum of four students per course; and course 4 will be offered six days a week for two weeks—four times a year—with a maximum of two students per course. Starting dates will also be flexible to fit physicians' schedule.

Faculty will include: Raymond P. Ahlquist, Ph.D., A. Calhoun Witham, M.D., Gerald Holman, M.D. and Mark Brown, M.D.

Travel beyond 25 miles and some subsistence will be paid participants. For further information, or to enroll for a course, contact: Bernard L. Hallman, M.D., Associate Dean, Emory University School of Medicine, 69 Butler Street, S.E., Atlanta, Ga. 30303, or Raymond P. Ahlquist, Ph.D., Associate Dean, Medical College of Georgia, Augusta, Ga. 30902.

(This program is one of 7 continuing education projects offered by the Georgia Regional Medical Program.)

THIRTY-SECOND ANNUAL MEETING SET FOR NEW ORLEANS GRADUATE MEDICAL SOCIETY

The thirty-second annual meeting of The New Orleans Graduate Medical Assembly will be held March 10, 11, 12, 13, 1969, with headquarters at The Roosevelt Hotel.

Nineteen outstanding guest speakers will participate and their presentations will be of interest to both specialists and general practitioners. The program will include fifty informative discussions on many topics of current medical interest, in addition to a clinicopathologic conference, medical motion pictures, round-table luncheons, and technical exhibits.

This program is acceptable for three and one-half prescribed hours and 28 elective hours by the American Academy of General Practice.

Pulmonary Embolism

THOMAS J. YEH, M.D., *Savannah*

IT IS DIFFICULT to envision a clinical condition which is related to so many specialities in practice of medicine and which is of interest to so many disciplines in basic science as pulmonary embolism. Originally thought of mainly as a postoperative complication, it is now clear that pulmonary embolism occurs whenever there is venous stasis, which is inherent in all conditions requiring inactivity or bed rest. Patients of all ages have been found to be subject to pulmonary embolism with perhaps the exception of the very young.¹ In a recent autopsy series, pulmonary embolism was found to be the single most common cause of death.² In another small but carefully studied series, evidence of old or recent pulmonary emboli was found in 64 per cent of consecutive autopsies.³

During the past five years this diagnosis was entered as a final diagnosis in 170 patients at Memorial Medical Center of Savannah. In this article I shall review some of the clinical features of pulmonary embolism, recent advances in the diagnostic measures, and present a rational approach to the management.

Origin of Emboli

According to one estimate 60-80 per cent of all pulmonary emboli arise from the veins of the lower extremities.⁴ The pelvic veins and the veins of the prostatic plexus account for another 15-20 per cent. In cardiac cases, among whom 30 per cent of all pulmonary embolism could be found, about 25 per cent of emboli is said to originate from the mural thrombus of the right atrium or right ventricle. Several cases of pulmonary emboli originating from the vein in the upper extremities were reported, but

they are distinctly rare.⁵ Thus, in patients without cardiac disease, virtually all pulmonary emboli originate from the veins draining into the inferior vena cava, and even in cardiac cases 75 per cent of the emboli originate from inferior vena cava tributaries.

Effect on Circulatory System

The effect of embolism is primarily on the cardiorespiratory system. The degree of cardiorespiratory embarrassment depends on the extent and acuteness of the obstruction of the pulmonary arterial bed. It is further modified by the presence of underlying cardiopulmonary disease such as heart failure, pulmonary congestion, or emphysema.

In acute massive pulmonary embolism, a large portion of the pulmonary arterial bed is obstructed, and this places the right heart under stress. The right heart may fail, but the clinical picture of shock is probably related to reduced left heart output which, in turn, is due to the inability of the blood to get across the pulmonary circuit to the left atrium. In the presence of relatively normal heart and lungs, approximately three-fourths of the pulmonary vascular bed must be occluded before a clinical picture of low cardiac output or shock will appear.⁶

When the embolus is small no drastic physiological consequence may be discernible initially. The embolus may undergo intravascular lysis partially or completely. With repeated emboli, the cumulative obstruction of the pulmonary vascular bed may reach a point where right heart failure becomes manifest.

Still, in other cases multiple small emboli may occur over a period of months or years to obliterate gradually the small pulmonary arteries with severe pulmonary hypertension as the result. The clinical

Presented before the Chest Section Meeting, 114th Annual Session of the Medical Association of Georgia, Augusta, May 5, 1968.

picture is mainly that of right ventricular hypertrophy and eventually right heart failure, with none of the acute pictures of clinical shock.

Pulmonary Physiology

In acute pulmonary embolism, the involved portion of the lung continues to participate in ventilation, but due to absence of pulmonary blood flow, it does not participate in gas exchanges. The effect of this is that end-expiratory PCO_2 is appreciably lower than arterial PCO_2 . This fact has been utilized in establishing the diagnosis of pulmonary embolism and in assessing the extent of vascular occlusion.^{7, 8}

Development of Hypoxia

Of greater importance is the development of hypoxia following a significant amount of pulmonary vascular occlusion due to emboli. In pulmonary embolism severe enough to warrant consideration of pulmonary embolectomy, arterial oxygen unsaturation is nearly always present. This is also true in the cases where chronic pulmonary hypertension has developed as the result of repeated small emboli.

The mechanism of hypoxia is not completely clear. Since it is not correctable by oxygen breathing, current thinking is that it is due to the opening of pulmonary arterio-venous shunting as the response to pulmonary hypertension.

Most recently bronchospasm, as manifested by wheezing, has been recognized as a feature of pulmonary embolism.⁹ This is attributed to release of a histamine-like substance from the platelets. The bronchospasm is adequately counteracted by heparin, an effect not shared by other anticoagulants.

Local Effect on the Lungs

In the absence of underlying cardiopulmonary pathology, even a sizeable embolus may not produce visible local lung changes. Infarction develops mainly in the patient with pulmonary congestion, such as in congestive heart failure. Infarcts may at times be accompanied by hemoptysis or pleural friction rub, and in some cases liquefaction and cavitation occur. Septic infarcts have resulted in lung abscesses. Pleural effusion, although usually an accompaniment of involvement of the pleural in infarction, has been observed in the cases where the embolism was not associated with infarction. In rare cases pneumothorax has resulted from sloughing of the infarct.

Clinical Diagnosis

Symptoms and signs are non-specific at best. In a small but well documented series of proven em-

bolism, pleural pain was present in only 55 per cent and hemoptysis in 25 per cent. Pleural friction rub was heard in 20 per cent of the patients and cyanosis was detectible in 15 per cent. Electrocardiogram showed no change in 75 per cent of the cases.¹⁰

The more frequent symptoms and signs such as dyspnea (100 per cent), accentuated second heart sound (95 per cent), and tachycardia (70 per cent) are difficult to evaluate in a patient who is already ill from an underlying disease, and who may be in congestive failure.

Serum enzyme changes, usually a combination of increased LDH and normal SGOT (83 per cent of cases) are not definitive enough for error proof diagnosis. Chest x-ray has often been normal in the face of massive embolism and infarcts are often indistinguishable from pneumonitis or atelectasis.

It is not surprising to find that in a series of patients with proven embolism, correct clinical diagnosis was made in only 30 per cent of the cases,¹⁰ and in another series of 78 cases with clinical diagnosis of embolism, only 41 per cent was proven later to have had embolism by pulmonary arteriography.¹¹

Definitive Diagnosis

For definitive diagnosis more specialized radiologic procedures are required.

Radioactive scanning of the lung using macroaggregated radioactive albumin, which is becoming more readily available in community hospitals, is a good screening test. The method gives a very graphic indication of regional pulmonary blood flow. The procedure is safe and entails little discomfort or risk, even in a very seriously ill patient.

The major drawback of this procedure is that the regional pulmonary blood flow is influenced by many other conditions, and a positive lung scan does not necessarily mean the presence of pulmonary embolism. Atelectasis, neoplasm, pneumonitis, and pleural effusion usually produce abnormal scans.

An even more serious shortcoming is the fact that patients with recent upper abdominal operation or thoracotomy frequently have abnormal lung scans.¹² Whereas a normal pulmonary scan is a reliable proof that there is no significant embolus, the diagnostic value of positive scan is limited. In patients with pulmonary hypertension resulting from multiple emboli to small arteries, a scan may be more accurate than a pulmonary arteriogram.

Pulmonary Arteriogram

With this possible exception, by far the most accurate method of detecting pulmonary emboli is by pulmonary arteriogram, and it can be said that definitive diagnosis of pulmonary embolism cannot

PULMONARY EMBOLISM / Yeh

be made without a pulmonary arteriogram. For detection of smaller emboli and for higher quality of study, the contrast material should be injected in the pulmonary artery by a catheter which is placed there by transvenous route. The pulmonary artery pressure is determined at the same time. This procedure, however, requires the electrocardiographic monitor, fluoroscopy, and availability of the electrical defibrillator.

An adequate pulmonary arteriogram can be obtained by injection of the dye in the right atrium through a large catheter (size 9 or 10 French). This may be a preferred method when the patient is critically ill and manipulation of the catheter in the right heart is considered too risky. By either method, serial films are preferred to single exposure technique.

Currently my approach is that if pulmonary embolism is likely, I would proceed with pulmonary arteriography directly, without scanning the lung. Lung scan is reserved for the cases where diagnosis of embolism is unlikely or where pulmonary arteriography may be too strenuous for critically ill patients. It has its greatest usefulness when chest x-ray is normal. In patients with abnormal chest x-rays, the pulmonary scan is by and large a wasted procedure. In other words, if one is seeking to establish diagnosis of pulmonary embolism, pulmonary arteriography should be performed. On the other hand, if one wishes to exclude embolism and is looking for a reason to avoid pulmonary arteriography then the lung scan would be the procedure of choice. If the scan is normal, this can be accepted as evidence that no significant embolism is present. If the scan is abnormal, diagnosis still has to be confirmed with pulmonary arteriography. Lung scan may be used to follow the resolution of emboli, once proven by arteriography.

Importance of Early Diagnosis

Since pulmonary embolism is a recurrent and progressive disease without treatment, it is mandatory that definitive diagnosis be made early. Even in cases of so-called massive pulmonary embolism, there frequently have been tell-tale signs of earlier small emboli, days or weeks before the catastrophic event. Aggressive diagnostic approach, adequate anti-coagulation, and interruption of vena cava, if indicated, certainly will save many more lives than an heroic effort at pulmonary embolectomy in the critically ill.

Use of Anticoagulants

Once diagnosis is made, the patient should be

anticoagulated with heparin. The most reliable method is by intravenous administration. Initial dose of 50 to 100 mgm. is given according to the size of the patient. Four hours later clotting time is determined. If clotting time is in the range of 20-30 minutes, the same dosage is repeated every four hours. If the clotting time is out of this range the dosage is adjusted. It is not necessary to do clotting time before each dose of heparin. Initially once a day, four hours after any of the dosage is sufficient. It must be remembered that heparin is eliminated or inactivated rapidly and clotting time is related to the time lapse after the previous dosage. Clotting time obtained without definite knowledge of the time lapse from the previous dosage is of no value in determining adequacy of anticoagulation.

For instance, 50 mgm. of heparin IV may result in a clotting time of two or three hours immediately after administration. At the end of four hours clotting time may be normal and hence dosage is inadequate.

Subcutaneous Heparin

Subcutaneous heparin is unreliable and has no place in initial treatment of patients with moderate to severe pulmonary embolism. Later, the subcutaneous route may be employed after dosage has been established. Two to eight days following initiation of heparin therapy, depending on magnitude of embolism and condition of the patient, coumadin may be substituted as an anticoagulant.¹³ The entire duration of anticoagulation should be two to six weeks.

Pulmonary emboli frequently undergo resolution under heparin therapy. Angiographic and scano-gram evidences are available to document resolution of emboli over a period of seven to 19 days.¹⁴

In patients with repeated small emboli and severe right heart strain (chronic cor pulmonale) anti-coagulant is recommended on a permanent basis.

Vein Interruption

When pulmonary embolism recurs in the face of adequate anticoagulation, or in patients with bleeding problems and in whom anticoagulation is contra-indicated, interruption of the vein by ligation, plication or partial occlusion clip must be undertaken to prevent further embolism and possible fatal outcome.¹⁵ The surgical procedure is simple and is attended by a very low mortality.

Whether ligation, plication, or clip is used perhaps is not as important as the fact that the operation is undertaken. Ligation is attended by higher incidence of stasis changes in lower extremities, particularly in those with past history of extensive deep vein thrombophlebitis and those with evidence of

venous incompetence. In cases of repeated multiple fibrin emboli with resultant pulmonary hypertension, or a patient with septic emboli, the ligation rather than plication or clip is preferred. All of these procedures are very effective in preventing fatal pulmonary embolism.

Pulmonary Embolectomy

Pulmonary embolectomy, as proposed by Trendelenburg in 1908, has been attended by an excessive mortality, and fatal outcome was the rule rather than exception. Cardiopulmonary bypass, as envisioned and later perfected by John Gibbon, was initially intended for massive pulmonary embolism. It is paradoxical that embolectomy with the use of cardiopulmonary bypass was not undertaken until 1961. According to a survey by Cross, the mortality of embolectomies performed with use of C-P bypass was 57 per cent and there was an additional 11 per cent late deaths, leaving only 32 per cent of long term survival.¹⁶ The results of two large series (Paneth¹⁷ and Sautter¹⁸) are similar (30 per cent, 25 per cent).

Since spontaneous resolution of pulmonary emboli can be expected and further emboli prevented by anticoagulation or vena cava interruption, pulmonary embolectomy is not indicated unless it appears that the patient will not survive without it. This will increase surgical mortality, but by adhering to this policy, more survival would be anticipated than a too aggressive and indiscriminate surgical approach to pulmonary embolism.

It is emphasized that in all patients undergoing pulmonary embolectomy, vena cava interruption should also be carried out.

Urokinase in Resolution of Emboli

During the past few years several investigators have used a fibrinolytic enzyme isolated from human urine (Urokinase) intravenously for lysis of pulmonary embolism with impressive results.^{19, 20} It is used by Sautter in three cases of acute massive embolism in which criteria for emergency pulmonary embolectomy existed.²¹ All patients survived. It has the advantage of removing clots from the pulmonary artery without the risk of surgery.

The rapidity with which the clots are dissolved is striking. Usually clinical effects are noticeable within a few hours after initiation of infusion, and in 24 hours a rather remarkable degree of thrombolysis is demonstrable by arteriography. This is much quicker than one anticipates the spontaneous resolution to occur under heparin therapy.

The enzyme is not readily available in large

quantities for general use or even widespread clinical trial as yet.

Summary

Pertinent anatomical, physiological and clinical features of pulmonary embolism are reviewed. Unreliability of clinical diagnosis is emphasized. Errors occur in both directions: over-diagnosis and under-diagnosis occur with appalling frequency without pulmonary arteriography, lung scan and/or detailed physiological study.

Once diagnosis of pulmonary embolism is established by arteriography, intravenous heparinization is the treatment of choice. With recurrence under adequate heparin therapy, or in the presence of hemorrhagic disorder contra-indicating anticoagulation, vena cava interruption by ligation, plication or clipping is indicated.

Spontaneous lysis under heparin therapy frequently results in resumption of blood flow to the once occluded pulmonary vascular bed. Embolectomy is indicated only if the patient is in irreversible hypotension and is not likely to survive without it. This approach will increase the surgical mortality but will enable avoidance of surgery in a substantial number of cases and probably will result in a greater number of ultimate survivals. Embolectomy is best performed with cardiopulmonary bypass. Urokinase holds great promise, and when it becomes commercially available, indication for embolectomy is certain to be reduced further.

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80 Years Ago

TWO CASES OF SALIVARY CALCULUS, ONE IN STENO'S, THE OTHER IN WHARTON'S DUCT

BY ARTHUR C. DAVIDSON, M.D., SHARON, GEORGIA

CASE 1. Mary V.; colored. Consulted me the 6th of March, 1884, with regard to a sore place in her mouth, on the right side of her tongue, far back, which she described as feeling sometimes like a splinter sticking in the side of her mouth. She said it sometimes festered, and that she could suck blood and matter from it.

Upon questioning her, she stated that it had been troubling her ever since about Christmas, and that it would sometimes swell up.

I examined it carefully but could not detect anything more than a small pustule, situated near the os ducti stenoniani of the right side, except that there was some tumefaction and hardness involving the whole of the parotid gland.

I gave her a simple mouth wash, consisting of a solution of zinc sulphate, and directed her to call again in a few days.

You can imagine my surprise when, after a few days, she returned, bringing in her hand a white large calculus, stating that the medicine had done "all the good, as this thing," holding up the calculus, "jumped out in my mouth this very morning."

It proved to be a salivary calculus, about ten lines in length and three lines in thickness. Was very hard, irregular and rough. It left a considerable hole from

which it had slipped out, and from which a little pus exuded for a few days, and then got well.

CASE 2. Miss Mary O'K., of this town, consulted me in December last, with regard to a lump and a soreness under her tongue, stating that it had given her no little uneasiness of mind, as it had been constantly troubling her for some months.

I could detect nothing more than an enlargement beneath the tongue, somewhat upon the left side, which was tender upon pressure. I advised her to let it alone until further development. This she was loath to do. Being a constant reader of the daily public press, she has seen much about cancer of the mouth and throat and was very much afraid that she was going to have a cancer, but decided to take my advice.

She again consulted me a few days ago with regard to the matter.

There was presenting through the mouth of Wharton's duct, on the left side, the end of a small, hard substance, which came away very readily upon pressure, greatly to the relief of my fair young patient.

It proved to be a calculus, about eight lines in length and about two lines in thickness. The tumefaction soon subsided and now the cancer is nearly well.

Why is it that no mention is made in our text books with regard to this affection? Does it belong entirely to the domain of dentistry and oral surgery?

From the Transactions of the Medical Association of Georgia, Thirty-Ninth Annual Session, 1888, Macon, Georgia.

Four situations are described in which this approach is believed to be advantageous.

The Development of the Anterior Surgical Approach for Cervical Disk Lesions

EXUM WALKER, M.D., *Atlanta*

THIS REPORT is based on 207 operations for cervical disk problems using the anterior approach. I had developed a technique for an anterior approach for surgery on the cervical spine several years prior to performing the first operation in 1955. This was conceived of and worked out while seeking a better way of removing osteophytes, as well as a means of accomplishing an interbody fusion for the control of discogenic pain.

I had been impressed with the simplicity of exposure of the cervical spine from in front at autopsy, and the ease of disk removal and the accessibility of any osteophytes for removal. At the time I was unaware of its occasional use by others, but later noted reports in the literature of its prior use by Stein,⁶ Bailey and Badgley,¹ Smith and Robinson,⁵ Osmond-Clarke,⁴ Dereymaeker and Mulier,³ and there may have been others. Since then, papers on the anterior approach have appeared in increasing numbers indicating growing interest.

An Additional Approach

The anterior approach should not replace the conventional posterior laminectomy but should add an additional approach to the cervical spine. The surgeon who masters both exposures can then choose either or possibly both procedures to accomplish his particular objective in a given case.

Advantages

The special advantages of the anterior approach cannot be fully appreciated until one has used it enough to become thoroughly familiar with the exposure, but I believe most surgeons who have done this have continued its use. There are obvious advantages and some disadvantages when compared

with the posterior approach. The exposure is much simpler and faster. It is only necessary to incise the skin and platysma muscle, together with some thin layers of fascia, to gain excellent exposure of the anterior surface of the cervical spine.

Closure Is Easier

Closure is also much easier since there is nothing to suture except the platysma and the skin. The entire disk can be easily removed and this cannot safely be done by the posterior approach. Any extruded fragments can be easily removed by removing the posterior annulus, exposing the dura, and any osteophytes that may be present can also be removed easily and with much less risk of trauma to the spinal cord or roots.

Fusion can be carried out more effectively and easier than it can be done posteriorly. Although

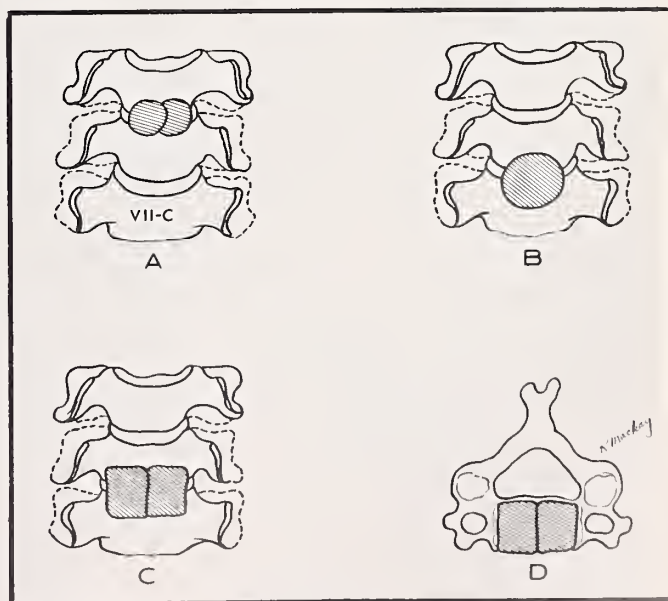


FIGURE 1

A and B show the use of double or single dowel grafts. C and D show the use of cuboidal grafts which may afford greater structural strength and stability.

Presented at the Annual Meeting of the American Academy of Neurological Surgery, San Francisco, California, October 17-21, 1966.

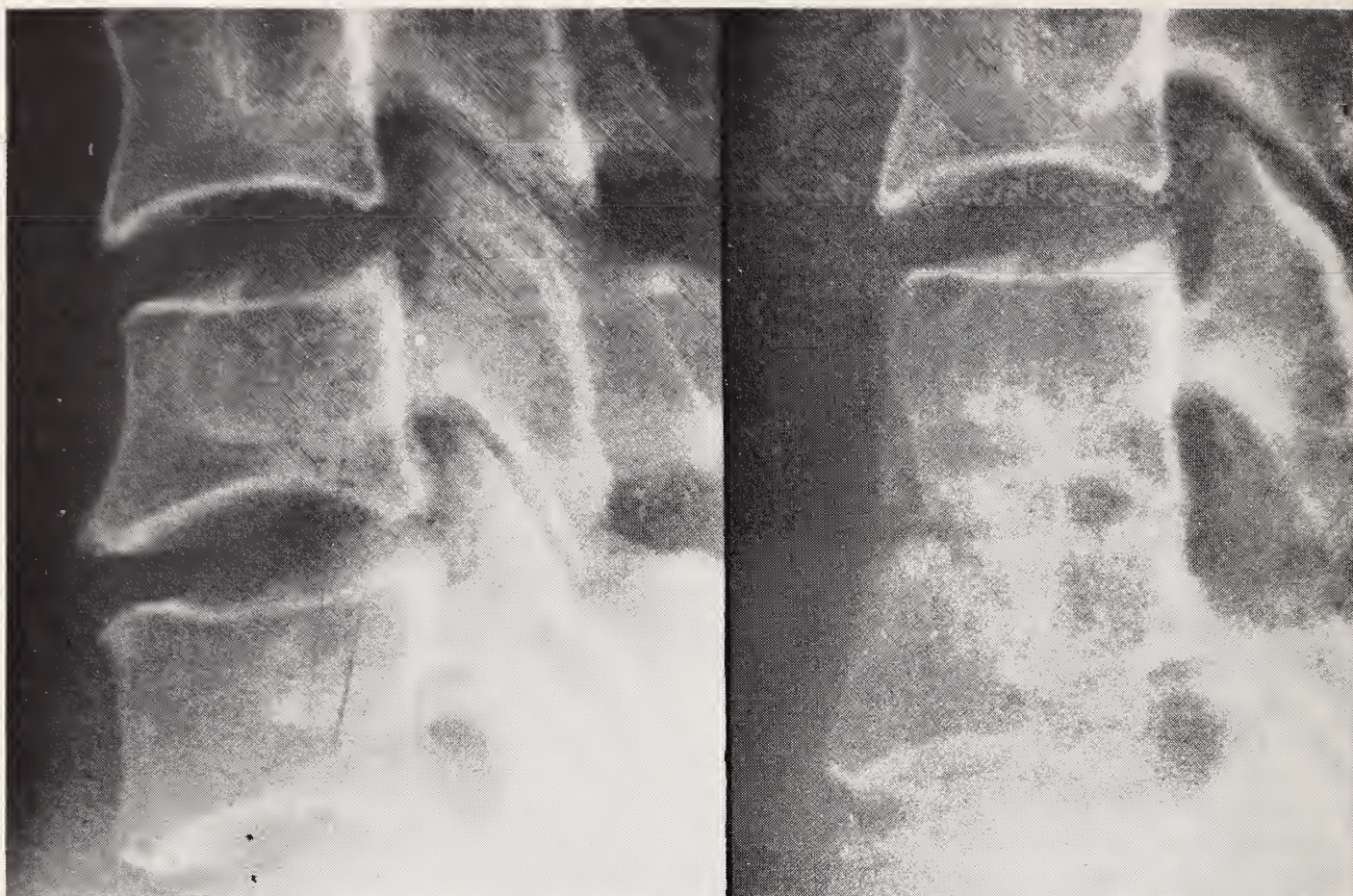


FIGURE 2

The changes of disk degeneration are shown on the left while on the right the completed fusion is shown. This was the first case in this series, surgery performed in 1955.

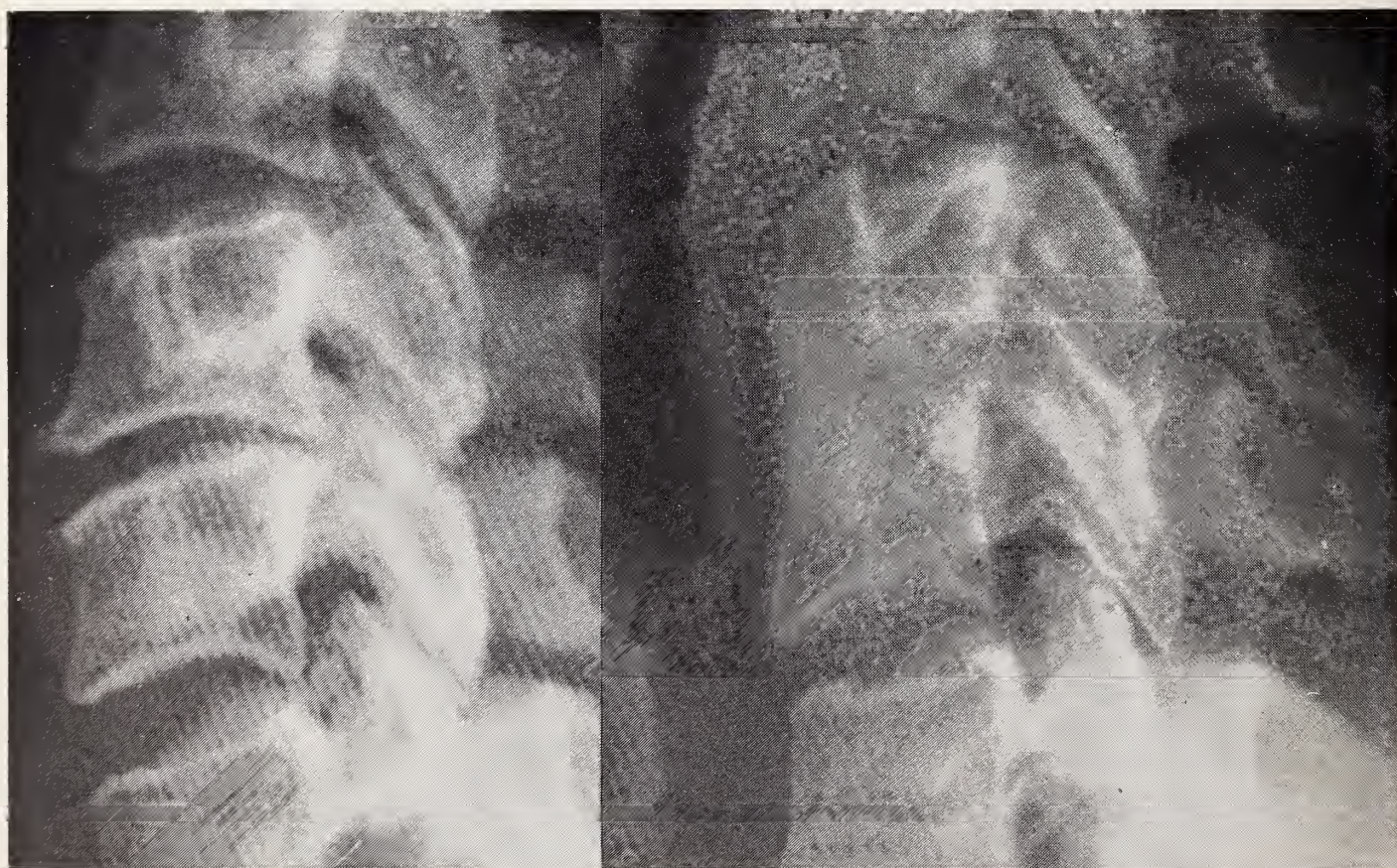


FIGURE 3

The disk degeneration is depicted on the left and the fusion on the right. Note the disappearance of the flaring of the vertebral margins.

fusion does not have to be done, I would recommend its routine use. Bleeding can usually be controlled and a dry field maintained so that surgery can proceed with precision and ease. There is no necessity to become involved in the epidural veins and since the cord and roots are scarcely disturbed, the risk of injury is much less than it is in the posterior approach. The careful placement of the retractors will avoid any compromise of the carotid or vertebral artery circulation or injury to the sympathetic trunk, the larynx or the esophagus.

Injury to Laryngeal Nerves

Retraction must be gentle to avoid injury to the superior or recurrent laryngeal nerves. This has occurred occasionally and caused some transient hoarseness and difficulty in swallowing and this is perhaps the principal disadvantage of the procedure.

Round or Square Plug Grafts

Fusion can be carried out using either round or square plug grafts (Fig. 1), but there should be enough cortical bone to maintain support, and avoid any compression collapse or angulation deformity about the graft. I have not used drains as advocated by some others. Hematomas have rarely occurred and none has drained spontaneously or necessitated aspiration. No wound infections have occurred.

Patients who have had surgery by both the anterior and posterior routes have invariably stated that there was less postoperative pain when the anterior approach was used. The use of a cervical collar, which I advocate postoperatively, must certainly be a nuisance to the patient.

Air Drill Simplifies Procedure

The basic technique of the approach has been well described by Cloward² and others and will not be repeated here, but the following comments reflect some of my personal ideas. Use of the air drill simplifies the exposure, as well as the removal of the posterior vertebral margins or osteophytes when desired and the shaping of the interspace in preparation for the grafts.

If the round dowel plug technique is used, the Stryker oscillating plug cutters for shaping the plugs and preparing the interspaces are superior to any of the hand drills or plug cutters which have been designed. Two small plugs placed side by side can be used in place of single larger central plug if desired. This has the advantage of providing room to use a distracting device, along with placement of the grafts further laterally to improve the initial fixation, as well as enlarging the grafted area for

ultimate maximum strength of the fused interspace. While the use of round plugs is simpler and more precise, the use of square plugs may be better.

Removing Posterior Annulus

The posterior annulus may be removed with a small thin angulated punch for exposure and decompression of the dura over the cord and nerve roots. It is advisable to complete any removal of the posterior annulus or osteophytes prior to shaping the interspace for the graft so that a dry field can be maintained. It is important to remove the cortex of the interbody space, but to remove the least cancellous bone possible, so that the grafted area can be thin to hasten osseous union. There should be ample cancellous bone of the graft in contact with cancellous bone of the vertebral bodies for rapid vascularization and osteogenesis, but with sufficient cortical bone aligned vertically to support weight bearing until osteogenesis can assume this function. This arrangement of the grafts should prevent graft collapse and angulation deformity. A collar is worn for about three months to lessen the stress on the grafts.

Most Effective Uses

This approach may be used in special circumstances such as for tumors which are anterior to the spinal cord, anterior fusion for post-laminectomy instability, or exposure of the spinal cord for cordotomy as described by Cloward, but is especially useful in the following major categories of disk disturbances.

(1) *Syndrome of acute nerve root compression*—The anterior approach is an ideal procedure for the relief of acute nerve root pain and is easier on the patient as well as on the surgeon than the conventional posterior approach. Since there is less nerve root manipulation, any sensory or motor loss is more likely to be improved than aggravated. The added fusion lessens the possibility of chronic pain or neuropathy over the long range.

(2) *Disk degeneration or injury of the cervical spine when the control of pain is the principal objective*—This group is a most challenging one because there is no simple practical solution and there are so many patients seeking relief.

It appears reasonable to assume that the primary pathology is the failure of one or more disks to withstand the stresses of function. The ideal treatment would be to restore the disk to normal, but this may never be a realistic possibility. Some day the disk might be replaced by some prosthetic device which could assume the functional requirements

DISK LESIONS / Walker

of the disk, but for this we must await further development. This leaves us for the present with the responsibility of doing whatever we can for these patients now.

Immobilization and Decompression

Immobilization by fusion along with decompression of any involved nerve roots appears to be the

Fusion can be performed much more effectively and simply by the anterior approach and decompression can be easily included when indicated. The surgical technique has been refined and is not difficult, but the selection of patients for surgery as well as the localization of the symptomatic disks requires a good deal of judgment. Involvement of multiple disks is the rule, and better methods of localization are needed.

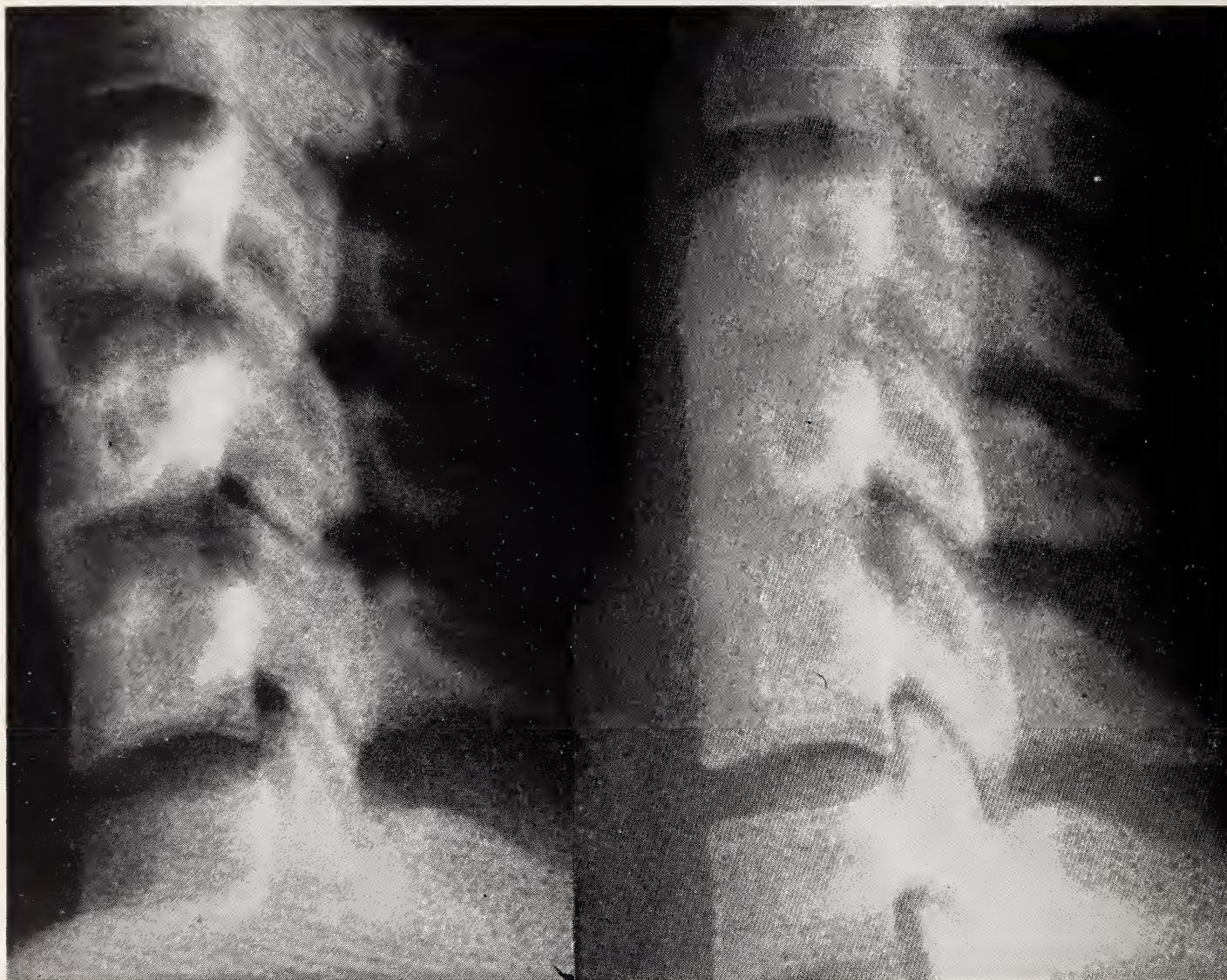


FIGURE 4

The grafts as they appear shortly after surgery are seen on the left while on the right the final fusion is shown.

most practical approach to this problem available at present, and experience has shown that when this has been accomplished the pain is often relieved. Traditionally, the neurosurgeons have been orientated toward decompression while the orthopedic surgeons have placed emphasis on fusion. Both are probably important, but when pain is primarily the result of disk degeneration, it would appear that fusion may be the more important factor in relieving pain, and clinical experience seems to bear this out.

Available localizing studies include neurological signs and symptoms, plain x-rays, including motion studies, myelography, discography and electromyography. There is no reliable way of being certain which disks should be repaired, but by considering all of the available evidence, and by allowing for a certain margin of error the patient can be offered a reasonable chance for improvement. Good results have been sufficient to establish this as an effective procedure. There remains the need of improved conservative management, in addition

to more accurate localizing aids, along with further refinement in surgical concepts and technique.

(3) *Fracture-dislocation of the cervical spine*—Interbody fusion after correction of any residual deformity markedly reduces hospitalization and the convalescent period and improves the final result. Surgery should be performed as soon as the patient's general condition permits and ambulation begun immediately. If there is spinal cord damage his rehabilitation program can be started without delay. The results of surgical fixation are so superior to the prolonged traction and immobilization by cast or brace that I would recommend its adoption.

(4) *Spondylosis with neuropathy*—The anterior approach to the cervical spine opens up new possibilities for treatment in this group. The spinal cord and nerve roots may be decompressed by removal of osteophytes and fusion performed, or a simple anterior fusion may be carried out followed by a decompressive laminectomy and facetectomy later.

While all of the exact factors causing spondylotic neuropathy are unknown, the basic problem may be simply the damaging effects of motion on crowded neural and vascular structures.

Many authors have described spinal cord and nerve root crowding between the disks and ligamenta flava, and some have pointed out the added compressive effects of motion, particularly extension, and posture. I suspect that the intermittent compressive forces resulting from motion of the neck may injure the spinal cord and nerve roots more than any static compression that may exist. If this should be the case then immobilization by fusion may prove to be more effective than any decompressive procedure.

From this line of reasoning I have performed anterior interbody fusion on some patients intending to do a decompressive laminectomy later. However, in some of these patients the improvement which followed the fusion was so remarkable that the second stage decompression was omitted.

Need Better Understanding

There is certainly a need for better understanding and treatment of this group of patients. The surgical emphasis in the past has been on decompressive procedures, but I would suggest that emphasis also be placed on immobilization, as this could be the more important factor.

Summary

The development of the anterior approach for surgery on the cervical spine is described and compared with the posterior approach. Points of tech-

nique are discussed. The anterior approach is suggested for: (1) Syndrome of acute nerve root compression; (2) disk degeneration or injury of the cervical spine when the control of pain is the principal objective; (3) fracture-dislocation of the cervical spine; (4) spondylosis with neuropathy.

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570-C Doctors Building
490 Peachtree Street, N.E.

NURSES TO GET INSTRUCTION ON INFECTION CONTROL

The U.S. Department of Health, Education and Welfare announces a course for nurses in "Surveillance, Prevention, and Control of Hospital-Associated Infections," to be held at the National Communicable Disease Center, Atlanta, Georgia, January 27-31, 1969.

The course, No. 1200-G is designed for nurse administrators—clinical and public health, nurse surveillance officers—infections control, and nurse educators. Areas to be covered include a review of basic principles of epidemiology; definition of the problem of hospital-associated infections; clinical features of infection; the laboratory in infections control; animate and inanimate environment in hospital-infections control; principles of sterilization and disinfection; principles of isolation, and administrative aspects of infections control.

The staff will be composed of authorities selected from professional schools, research institutions, the Public Health Service and other related fields. Inquiries and applications should be addressed to the National Communicable Disease Center, Atlanta, Georgia 30333, Attention: Chief, Health Professions Training Section, Training Program.

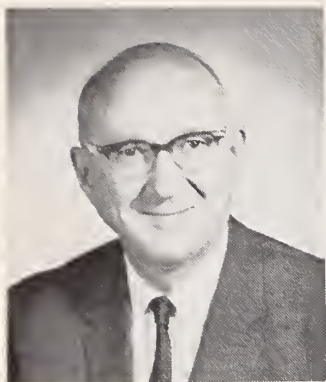
Second Annual

COMMITTEE CONCLAVE

July 26-27, 1969

Marriott Motor Hotel

Atlanta, Ga.



SOME THOUGHTS ON MEDICARE

THE MEDICAL ASSOCIATION OF GEORGIA is indeed fortunate to have among its interested membership one such as Dr. Charles S. Jones who is most knowledgeable concerning all phases of our insurance programs, both private and Federal. He has been most generous with his time for the benefit of his fellow doctors and to create closer alliance and understanding between insurance companies and the Medical Association of Georgia. The remainder of this letter is almost entirely made up of thoughts which he has expressed, particularly with regard to the Medicare Program Part B.

This program has been in effect about two and one-half years, and the scope of its activities may well be surprising to many. At present, the John Hancock Company, the carrier for this program in Georgia, is processing about 60,000 claims per month, with payments amounting to about \$1.5 million monthly. These figures indicate that the average doctor's bill for medicare patients is \$25. In Georgia there are about 323,000 people covered under Part B. Formerly, a large number of those who were unable to pay for medical care came from this segment of our population. Under the "usual and customary" principle, these people are now paying their own way.

Georgia Physicians Are Cooperating

In Georgia the doctors are cooperating with this program extremely well. Of the 60,000 claims processed monthly only about 20 claims are in dispute. This is well under one tenth of one per cent. There are very few federally administered programs which have such an admirable record. Actually, an analysis of disputed claims indicates that 90 per cent fall into the category of "over-utilization," which makes the record look even better.

Several months ago a set of utilization rules was established nationally. These designate the amount of care for the chronically ill covered by medicare payment in cases where more care is medically indicated and additional payment will be made. In cases where the patient wants or demands care beyond the "rules," payments cannot be made by medicare.

Settling Disputed Claims

At present, disputed claims are adjudicated by practicing physicians in Georgia. This is done through insurance review committees over the State; it is also incumbent upon local utilization review committees to carry out their duties. The final mechanism for settling claims is known as the "fair hearing" method. By this method a claim is settled by a judge and his decision is final. The judge will be a layman selected by the insurance carrier. Obviously it is certainly more desirable for the doctors to handle these claims than to have the "fair hearing" invoked. John Hancock Company has not used the fair hearing approach as yet, and certainly will not if our insurance review committees function well.

The medicare program is BIG. It is functioning well. There are admittedly some undesirable areas. It seems most important for us to iron out these aspects of the program within our own organization. If we fail in this capacity, lay judges will make the decisions. If we once lose the opportunity to settle our own differences, we may be unable to regain it.

Charles R. Andrews Jr. M.D.

*Charles R. Andrews, Jr.
President, Medical Association of Georgia*

TRAINEESHIPS OFFERED FOR CLINICAL PHARMACOLOGISTS

Continuing efforts to help meet the nation's future demands for clinical pharmacologists were announced recently by the Pharmaceutical Manufacturers Association Foundation. Through a traineeship program in clinical pharmacology established in 1966, the Foundation is again providing twenty medical students with opportunities to acquaint themselves with basic scientific knowledge and techniques in the field.

Foundation Executive Director, Thomas E. Hanrahan, explained that the program provides a stipend per student of \$1,000 for a three-month period. A total of 40 awards to students at 21 medical schools have been made during the program's first two years.

The program supplements the Foundation's program of faculty development awards in clinical pharmacology. These awards are offered to medical schools for salary support of full-time junior faculty positions in clinical pharmacology.

Further details are available from the PMA Foundation which was established in 1965 by the Pharma-

ceutical Manufacturers Association "to promote the betterment of public health through support of scientific and medical research, with particular reference to the study and development of the science of therapeutics." The Foundation is located at 1155 Fifteenth St., N.W., Washington, D.C. 20005.

CHILDREN'S HOSPITAL OPENS RETINOBLASTOMA CLINIC

St. Jude Children's Research Hospital announces the establishment of a Retinoblastoma Clinic for the diagnosis and treatment of tumors and other diseases of the retina in children.

For further information write Charles B. Pratt, M.D. or David Meyer, M.D., St. Jude Children's Hospital, 332 North Lauderdale, Memphis, Tennessee 38101.

MAG'S NEW HEADQUARTERS



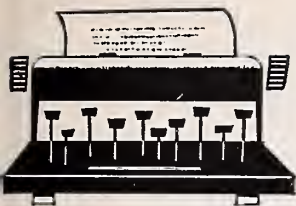
October 29, 1968—Exiting to the rear of the property is one load of the 800,000 cubic feet of dirt removed from the lot to make way for the parking decks. The new facility will accommodate 150 cars.



September 13, 1968—Work begins as all cars are barred from the old parking lot and the paving is removed by the excavating contractor. The grass slopes and trees will give way to the modern new addition.



November 1, 1968—Progress begins to show as the wall forms are gradually filled by the crane-bucket with thousands of yards of high-pressure concrete around the steel reinforcing.



AMA Establishes New Division of Public Affairs

THE AMA HAS ESTABLISHED a new Division of Public Affairs which will assume the functions of the Division of Field Service, and amalgamate the AMA and AMPAC field staffs into one. The new Division will assume broader responsibilities in the public affairs area including community, civic, and governmental activities.

Specifically, the new Division, headed by former AMPAC Executive Director, Joe D. Miller, will be charged with implementing AMA policy as it affects continuing relations between government and medicine, and be responsible for many of the education and research programs formerly conducted by AMPAC.

Field Office in Atlanta

An AMA Field Office will be established in Atlanta, and former AMPAC Field Man, J. Tom Sawyer, will staff that office with AMA liaison responsibility for the States of Georgia, Florida, North Carolina and South Carolina.

Renal Transplantation

ABOUT FIFTEEN YEARS AGO I attended a discussion among Drs. George Thorn, John Merrill and David Hume concerning renal transplantation. They had been meeting for months at frequent intervals, had done a number of animal experiments and had even tried several human transplants in hopeless patients. After seeing at autopsy the extensive destruction of the donor kidney by the recipient, it seemed fanciful to think that they could ever succeed. Just a few years later, their group performed seven successful transplants between identical twins.¹

At that time, marrow was being removed and preserved and the recipients were being subjected to whole body radiation sufficient to destroy the marrow. Then the marrow was reimplanted later. There were occasional successes, but those seemed fortuitous.

At the present time, the use of Azathioprine, Prednisone, and antilymphocyte serum has produced as high as 95 per cent good results in related donors,² and 65 per cent in cadaver transplants. Unfortunately, there have been serum reactions from antilymphocyte serum and there has been some difficulty in withdrawing recipients from the serum.

Typing Leukocyte Antigens

Humphries and associates³ in this issue point out some of the laboratory problems in transplantation. They describe one of the most recent and most important advances: that of typing of leukocyte antigens. When these and red blood cell antigens are matched in non-related donors, the results so far have been as good in non-related as in related donors. There are only three main groups of the leukocyte antigens.

They also describe the improved methods of preservation of cadaver kidneys which have improved early results in this area.

Perdue and associates⁴ describe some of the clinical problems, such as use of immunosuppressive drugs in rejection reactions and outline technical surgical difficulties.

Imprecise Methods

A number of different organs have been transplanted and new successes may be anticipated.

As Starzl states,⁵ "Methods of organ transplantation employed now will seem ridiculously imprecise to future generations of physicians." One can visualize the possibility of many improvements. Organs from living donors cannot nearly satisfy our needs and methods of preserving, typing and banking organs must be devised. Also, we cannot ask healthy individuals to undergo the risks of surgery.

We need new methods of selective immunosuppression by new drugs which reduce the present danger of suppression of our defense mechanisms. Perhaps greater advances in tissue typing and matching will be the most important breakthrough. Lastly, means must be found to reduce the great complexity and expense of transplantation if it is to become more than just a spectacular research procedure.

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3. Pages 5-7, this issue.

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Arthur J. Merrill, M.D.

Medicare Costs to Increase

BEGINNING JANUARY 1, 1969, Medicare patients will pay a 10 per cent increase in the deductible for hospital care when the patient will have to pay the first \$44 of his hospital bill instead of the present \$40. The 10 per cent increase will also apply to other charges paid by patients in hospitals and nursing homes. The original \$3 per month for Part B of Medicare (physicians' services) has already been increased to \$4 per month.

Coverage for All Citizens

HEW Secretary, Wilbur J. Cohen, in announcing the Medicare cost increase at a meeting of the American Hospital Association, also said that he favored the extension of government health insurance so that by 1976 all citizens would be covered. Cohen also proposed that the present \$4-per-month charge for Part B coverage be discontinued and that the Part B cost be taken from regular Social Security Funds.

Cost Is Unknown

At the same time, he said that he could not estimate how much his proposal would cost the government, but that Vice President Hubert Humphrey had indicated he favored the plan. An educated guess would be that President-elect Richard Nixon may prefer a change in both the proposed plan and HEW Secretaries.

Highlights of 1968 AMA Clinical Convention

The following summary of the activities of the AMA House of Delegates is given for the purpose of touching upon the more important items undertaken at the 1968 CLINICAL CONVENTION in Miami Beach, Florida. It is not intended as a detailed report of all the actions taken.

THE AMA HOUSE OF DELEGATES met, received and considered a large number of reports and resolutions at its Clinical Convention in Miami Beach, December 1-4, 1968. Of the 242 Delegates present, 240, or 99 per cent were in attendance during the two final days when reports and resolutions were approved, amended or rejected by the House. Ninety-four items of business were brought before the House including 22 reports from the Board of Trustees and 62 resolutions from State Medical Associations and AMA Scientific Sections.

Organ Transplants

The House adopted a statement on heart transplantation which made these five points:

(1) The preservation of good medical practice demands that the evolution of therapy be orderly. "The staff of a hospital or medical center planning to initiate such a program should have: (a) adequate background in animal research so that experience is gained as to the problems, potentials and limitations of cardiac transplantation; (b) experience in immunosuppressive therapy and an adequate source of antilymphocyte globulin of known quality; (c) a protocol of clinical research adequate to follow and evaluate the course of the patient."

(2) Due regard for the welfare and safety of each individual patient is paramount.

(3) Heart transplantation has brought certain medical, ethical and legal questions into critical focus. "Paramount among them is the determination of death. The right of the prospective donor to the best possible medical care—a right which his potential role as organ donor must not be allowed to abrogate—must remain sacred. The growing ability of medical science to maintain some form of biological function for prolonged periods adds to the difficulty of defining the point of irreversible dissolution.

"The cause of death must be evident and of an irreversible type. The fact of death must be established by adequate, current and acceptable scientific evidence in the opinion of the physicians making the determination. The determination of death in organ donors must be made by no less than two physicians not associated with the surgical team performing the transplant."

(4) The potential of heart transplantation, whatever that may prove to be by subsequent clinical experience, will be "severely limited by the shortage of potential organ donors. . . . Basic research into the causes of heart disease and of hypertensive vascular disease is . . . of vital importance, since the only ultimate solution to the problem of heart disease lies in its prevention."

(5) "Human heart transplantation has been accompanied from the onset by a degree of public awareness and attention almost without parallel in medicine. . . . It is imperative, therefore, that the public be made fully aware of the potentialities and limitations of heart transplantation as those are currently understood and as that understanding is modified by subsequent experience. . . . Only by preserving public confidence in the judgment of the physician, can the orderly progress of medicine be maintained."

AMA HIGHLIGHTS / Continued

The House also approved the Uniform Anatomical Gift Act and urged each State medical association to give it careful consideration "with a view to seeking its adoption in its state."

Osteopathy

The House adopted a Board report stating these objectives with respect to osteopaths:

To "assure the provision of the best possible health care to the American people; make available to students and graduates in osteopathy, education of the same high standards as prevail in undergraduate, graduate and continuing educational programs in medicine; provide avenues whereby qualified osteopaths may be assimilated into the mainstream of medicine."

To achieve those objectives, the AMA recommends that each school of osteopathy improve its teaching program by strengthening its faculty and improving its facilities and resources; invites schools of osteopathy and their accrediting agencies to consult with the AMA and the Association of American Medical Colleges; suggests that accredited hospitals may accept qualified osteopaths on medical staffs; suggests that medical specialty boards may accept osteopaths for examination if they have completed AMA-approved internships and residency programs and have met other regular requirements; requests that as specialty boards declare intent to permit examination of osteopathic graduates, appropriate AMA-approved residency programs be opened to qualified osteopathic graduates; suggests opening AMA-approved internships to qualified osteopathic graduates; recommends that determination of qualification be made at the level of the medical staff, the county medical society or the review committees and boards having appropriate jurisdiction; and suggests that AMA, State and county societies and other affected organizations "may proceed to make such constitution and bylaws changes as are necessary to implement the foregoing."

The House also "suggests that each county and State medical society may accept qualified osteopaths as active members and thereby provide for their membership in the American Medical Association" and instructed the Council on Constitution and Bylaws to prepare "appropriate Bylaw amendments so that qualified Doctors of Osteopathy may be admitted to full active membership" in the AMA.

Anti-Discrimination

The House adopted two amendments to the Constitution and Bylaws that (1) relate to the denial of membership in the AMA or any of its constituent associations by reason of color, creed, race, religion or ethnic origin and (2) disciplinary procedures to be followed in instances of violation of this amendment. Membership shall be guaranteed pursuant to the following amendment:

"Membership in the American Medical Association or in any of its constituent associations shall not be denied or abridged on account of color, creed, race, religion or ethnic origin."

Provision for disciplinary action in the event of violation of the above amendment is provided by the following amendment:

"If the Council [Judicial] determines that allegations [of discrimination against physician applicants for membership] are indeed true, it shall admonish, censure or, in the event of repeated violations, recommend to the House of Delegates that the state association involved be declared to be no longer a constituent member of the American Medical Association."

Allied Health Personnel

The House agreed with the Council on Health Manpower regarding the need for physician prescription and supervision of all ancillary services provided in the hospital by adopting a Board of Trustees report on the utilization of paramedical personnel. In adopting the report, the House stated that "the medical staff should concern itself with contractual agreements between various allied health professionals and the hospital only insofar as, and to the extent that, such agreements tended to remove the provision of ancillary services from the prescription and supervision of the physician."

Matters of Patient and Public Interest

The House adopted a report on the "Special Requirements for Residency Training in Family Practice" and resolved that the AMA "Affirm the importance of providing appropriate recognition for family physicians through approval of a primary specialty board for family practice and that the Council on Medical Education be encouraged to continue its efforts with the American Academy of General Practice and the AMA Section of General Practice to achieve this goal."

Pictorial Highway Signs

The House also adopted a report encouraging the American Association of State Highway Officials and the Federal Highway Administration to work toward the adoption of the International System of Highway Signs which avoids the use of language in order to make visits of foreigners to the U. S. "as safe and pleasant as possible."

In addition the House voted to urge constituent societies in those States where existing laws do not permit minors to consent to treatment for venereal and other communicable diseases "to seek to enactment of such legislation."

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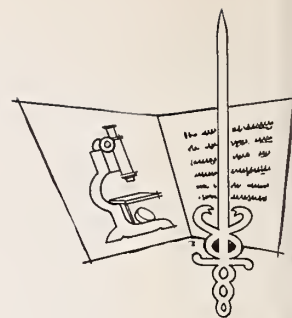
MAG FOUNDATION

Form of Bequest

I give and bequeath to the Medical Association of Georgia Foundation, Inc., 938 Peachtree Street, N.E., Atlanta, Georgia 30309, the sum of dollars \$ (.....) to be used by the Board of Trustees of the Foundation for

.....
(state purpose of gift if restricted)

Signed



CANCER TERMINAL CARE

A. H. LETTON, M.D.*

FOR MANY YEARS we have sent our terminal cancer patients to Our Lady of Perpetual Help. The families have often expressed their appreciation, but I had never been there until recently. I went to see. I guess I had always feared going because of what I would see. I was so wrong. I was cheered by what I saw.

Cheerful Atmosphere

The building is old. It was the Hebrew Orphanage in 1939 before the Sisters took it over. The rooms are large, bright, airy, clean and neat. The equipment is modern and new looking. The whole atmosphere is happy. I was astonished. Here were patients sitting in easy or wheel chairs, lying in bed watching T.V., talking and joking with each other. This wasn't the depressed atmosphere I had expected where incurable cancer patients were gathered to await the grim reaper. These people were at ease with themselves and the world and obviously, with their Lord.

As I wandered among the patients, I was pleased to note they were immaculately clean. Their robes, pajamas or nightgowns were fresh. The bed linen was bright, no stains.

Sister Marie Cordis escorted me out on the back porch. The view was wonderful. A large white oak stood like a fan with gold, red and green leaves, behind it a forest of fresh green Georgia pines. Under the oak, peacocks paraded. Roses and chrysanthemums bloomed, a beautiful, serene scene. I could understand the words of the executive editor of one of our newspapers who had written, "Many patients, afraid when they arrive, attain a serenity which is touching and astonishing. All of them move inexorably toward the last day or night, the last minute of life with a calm and even cheerful resignation."

They have cared for almost 8,000 patients in the past 29 years—about twice as many white as colored. About one in seven is Catholic. The others are from all other denominations.

Founded in 1900

The Order was founded by the daughter of Nathaniel Hawthorne in 1900 and now maintains seven houses. They will not accept pay from the patient. Their work is the care of incurable cancer patients, supplying medical attention, nursing care and medication. In fact, all the patients' needs or wishes are supplied so that they will be comfortable and free from physical, emotional or financial pain. In addition, they furnish the members of families with clothes or food when there is need, and they have facilities for care for burial if the family desires.

This is a wonderful institution. I can recommend it to you for the care of your cancer patients who need terminal care. The requirement for admission is a doctor's certificate stating that the patient has incurable cancer.

340 Boulevard, N.E.

* Chairman, Executive Committee of Medical-Scientific Committee, American Cancer Society.

NURSING LIAISON COMMITTEE

THE LIAISON COMMITTEE of MAG with the Georgia State Nurses Association has drawn up a "Joint Position Statement on Nursing Practice" which has been approved by appropriate bodies of each association. In brief, this statement urges the appointment of a representative committee in every health care institution or agency to determine and implement policies for carrying out procedures and solving problems relating to nursing practice and other health disciplines.

Urgent Need for Planning

The need for such planning is becoming more urgent as technical, scientific and medical advances bring about changes in the traditional areas of medical and nursing practice.

Two such joint statements have been approved and copies have been mailed to hospitals, nursing homes, and community agencies. One is on "intravenous administration of fluids, blood and its derivatives, and drugs by registered nurses licensed to practice in the state of Georgia" and the other "the registered nurse and emergency resuscitative measures." The latter is also endorsed by the Georgia Heart Association, Georgia Hospital Association and the Georgia State League for Nursing.

Major Provisions of Statements

The crux of both statements lies in the provisions that:

- (1) The nurse has had special competent teaching and supervision in the technique;
- (2) The nurse performs the technique upon order of a licensed physician or pursuant to standing procedures established by the agency; and
- (3) The nurse has qualified for the procedure in the specific health care agency in which she is working.

Copies of the above statements may be obtained from the Georgia State Nurses Association.

This Committee will be glad to have your comments and suggestions for its consideration and action.

*Charles Eberhart, M.D., Chairman,
MAG Nursing Liaison Committee.*

THE MONTH IN WASHINGTON

The incoming Administration work on a health program was started with President-elect Richard Nixon's appointment of John Dunlop, a Harvard University professor, to head a special task force. Dunlop, 54, is a prominent economist and an expert in the manpower field. He has been a frequent adviser to the Federal Government since 1948.

Cohen Lists Health Goals

In a letter to employees of the Department of Health, Education and Welfare, Secretary Wilbur J. Cohen, who will return to teaching at the University of Michigan, listed 13 health goals for the 1970's. He previously had said that his teaching position would leave him time to work for new and expanded health programs.

Most of the goals are non-controversial, and Cohen did not elaborate on details of implementation where controversy arises. The goals are:

- Continued expansion of medical research and more rapid dissemination of new knowledge to prevent and cure illness.
- Elimination of economic barriers to medical care, through comprehensive health insurance and other public and private programs.
- Major reduction in infant mortality and early childhood diseases.
- Elimination of malnutrition.
- Improvement in the organization and delivery of medical care, with continued emphasis on high quality.
- Widespread transplantation of human organs and development of artificial organs.
- Expanded prevention and improved chances of recovery from heart disease, stroke, and cancer.
- Increase of health manpower and better use of professional skills.
- Elimination of large mental institutions and expansion of community mental health centers accessible to all.
- Family planning services available to everyone.
- Improvement in the quality of the environment, with major reduction in air and water pollution.
- Reduction of alcoholism, drug addiction, mental illness and mental retardation, and accidents.
- Elimination of smallpox, diphtheria, polio, whooping cough, and measles.

Two Drugs Tested

Developments in the drug field include starts on tests of an old drug in treatment of pneumonia and a new one for Parkinson's disease.

The National Institutes of Health started a widespread test of a polyvalent pneumococcal vaccine that was discarded 20 years ago with the entrance of antibiotics. Edwin M. Lerner, M.D., coordinator of the test program, said it had been demonstrated that persons die of pneumonia because of early stage damage and that antibiotics have not been a cure-all. The old vaccine, manufactured by E. R. Squibb and Sons, was licensed and found effective in 1948, but was taken off the market in 1952 because of lack of sales.

L-Dopa for Parkinsonism

The Public Health Service announced a program to

test an experimental drug in treatment of Parkinson's disease. Robert Q. Marston, M.D., Director of the National Institutes of Health, said the drug, L-Dopa, may help "up to 75 per cent of patients." But he cautioned it has "serious and unpleasant side effects" which must be carefully checked.

Other developments in the drug field included:

PMA vs. HEW Task Force

The Pharmaceutical Manufacturers Association disputed the finding of an HEW Task Force on Drugs that a \$41.7 million saving could have been obtained by use of generic instead of brand name products in 67 of the 409 prescription drugs used most often by elderly persons. C. Joseph Stetler, PMA president, said the claim was not documented and was based "on the unproven assumption that prescriptions written by generic name cost substantially less."

The Pill and Cervical Cancer

A Food and Drug Administration Advisory Committee said that existing data on whether birth control pills can cause cancer of the cervix is still inconclusive. The Advisory Committee on Obstetrics and Gynecology repeated the recommendation of the World Health Organization that all women using birth control pills undergo 6-12 month medical examinations.

Computerized Drug Data

The government has drawn up a national drug system to permit computerized processing of drug data. The code is designed to provide the needed common language in which to communicate rapidly and accurately essential information about drugs. The code was drawn up by HEW and the Drug Trade Conference, which represents drug manufacturers and distributors.

Active Georgia RMP

Regional Medical programs, a majority involving continuing education of physicians, are now underway in 24 areas, with 261 separate projects being carried out, according to a government report. Thirty-one regions have not yet embarked on specific programs.

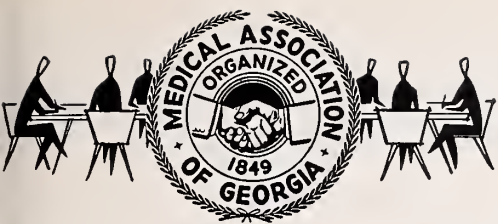
States and regions with the most listed projects to date are Tennessee (mid-South), 27; Missouri, 25; Texas, 24; South Carolina, 16; Intermountain (Utah, Wyoming, Montana, Idaho, Nevada), 16; Michigan, 15; Georgia, 14; Kansas, 14; Washington-Alaska, 4; Albany (N.Y.), 10; Memphis (Tenn.), 10; California, 9; Rochester (N.Y.), 9; and, Oregon, 7.

Man's Worst Enemy

Man is threatened with self-destruction because he has damaged, ignored and contaminated "the earth that gives him life," according to a Federal government official.

Charles C. Johnson, Jr., Administrator of the newly created Consumer Protection and Environmental Health Service in the Department of Health, Education and Welfare, said the threat—from pollution, unsafe food, drugs, water and chemical additives to food,—among other things—is increasing each year.

Johnson spoke at a symposium on Human Ecology.



THE ASSOCIATION

NEW MEMBERS

Balentine, J. Douglas, M.D. DE-4—Fulton—Path.	Emory University School of Medicine Atlanta, Georgia 30322
Brown, Elbert H., M.D. Active—Peach Belt—GP	212 Hospital Drive Warner Robins, Georgia 31093
Chandler, Neal W., M.D. Active—Fulton—R	1405 Clifton Road, N.E. Atlanta, Georgia 30322
Davis, Terrell L., M.D. Active—Richmond—Pd	Gracewood State Hospital and School Gracewood, Georgia 30812
Edwards, Charles H., M.D. Active—Fulton—P	3390 Peachtree Road, N.E. Atlanta, Georgia 30326
Feigenbaum, Ernest, M.D. Associate—Fulton—PH	50 Seventh Street, N.E. Atlanta, Georgia 30323
Finney, Herman R., M.D. Active—Richmond—U	1502 Anthony Road Augusta, Georgia 30904
Flint, Lucien A., M.D. Active—Cherokee- Pickens—R	R. T. Jones Memorial Hospital Canton, Georgia 30114
Forrester, Edward S., Jr., M.D. Active—Richmond—OR	1021 15th Street Augusta, Georgia 30901
Gindin, R. Arthur, M.D. Active—Richmond—NS	Talmadge Memorial Hospital Augusta, Georgia 30902
Goodrich, Samuel M., M.D. Active—Richmond —OBG	Medical College of Georgia Augusta, Georgia 30902
Hendry, Charles H., M.D. Active—Fulton—P	445 Capitol Avenue, S.W. Atlanta, Georgia 30312
Mees, Donald E., Jr., M.D. Active—DeKalb—GP	5372 Peachtree Street Chamblee, Georgia 30341
Mulliniks, Robert C., Jr., M.D. Active—Cobb—OBG	2404 Austell Road Austell, Georgia 30001
Nelson, Maynard, M.D. Active—Richmond—SU	1247 15th Street Augusta, Georgia 30901
Saunders, Elwyn A., M.D. Active—Richmond—OR	Medical College of Georgia Augusta, Georgia 30902
Saunders, William H., Jr., M.D. Active—Cobb—GP	2404 Austell Road Austell, Georgia 30001

Searcy, Ashburn P., M.D. Active—Richmond —ANES	1511 Anthony Road Augusta, Georgia 30904
Sisson, John M., M.D. Active—Thomas-Brooks —SU	Archbold Hospital Thomasville, Georgia 31792
Smith, Miriam F., M.D. Active—DeKalb—P	1275 McConnell Drive Decatur, Georgia 30033
Strese, Fritz W., M.D. Active—Cobb—GP	Lockheed Georgia Company Medical Dept. Marietta, Georgia 30063
Threlkeld, William A., M.D. Active—Richmond—P	1467 Harper Street Augusta, Georgia 30902
Turner, Don W., M.D. DE-4—Fulton—P	P. O. Box 29457 Atlanta, Georgia 30329

SOCIETIES

The **Richmond County Medical Society** has commended the Citizens and Southern National Bank on its "Fall Cleanup Plan," and offered its support and assistance in the project.

The **Georgia Medical Society** recently dedicated a bronze plaque memorializing its past presidents. The ceremony took place in conjunction with the dedication of Candler Hospital's Minis-Gilmer Diagnostic and Treatment Center.

The Comptroller General of Georgia, James L. Bentley, was the guest speaker at the November 20 meeting of the **DeKalb County Medical Society**. Mr. Bentley spoke on the "Insurance Needs of Our State and Nation."

PERSONALS

First District

T. A. Peterson, of Savannah, has been reelected as vice president of the Georgia Easter Seal Society for Crippled Children and Adults.

Second District

The keynote speaker at the Ladies Night dinner of the Tifton Toastmasters was **Joe Turner**. The topic of Dr. Turner's speech was "The Eternal Mystery."

At the November meeting of the Albany Kiwanis Club, **Charles D. Hollis** and **A. M. Freeman** discussed heart transplants, mechanical organs for the human

THE ASSOCIATION / Continued

body, and the proper metals for such organs. **Charles Lamb** was program chairman for the luncheon.

John A. Meier, Albany orthopedist, has been cited by the Georgia Easter Seal Society as the first recipient of the organization's volunteer-of-the-year service award. Dr. Meier was recognized for his 11 years of service as medical director of the Southwest Georgia Easter Seal Rehabilitation Center, establishing and maintaining a high level of professional services for the Albany Center's patients. He was also commended for serving as Chairman of the Professional Advisory Committee to the Center and for helping to plan the expanded rehabilitation facility to be built in Albany in 1969.

Third District

A. J. Morris of Montezuma was installed recently as president of the Third District Medical Society. He succeeds **Henry H. Boyter** of Columbus.

Fourth District

Tom Graham of Newnan recently addressed the Newnan Kiwanis Club on the subject of "Capitalism—a Forgotten Ideal."

Fifth District

Colon H. Wilson, Jr. and **F. James Funk** of Atlanta were participants in a panel discussion on the "Advances in Orthopedic Management of Rheumatic Disease." The panel was part of the program at the recent meeting of the American Rheumatism Association held in Atlanta.

John R. Lewis has been named president of the new Society of Aesthetic Surgeons.

At the annual meeting of the American Medical Women's Association, **Irene A. Phrydas** of Atlanta was installed as the Councilor of Liaison with Other Organizations.

Bruce Logue recently served as visiting Professor of Medicine at Georgetown University Hospital, in Washington, D.C.

Members of the Southern Medical Association have elected **Edgar Boling** as Chairman of the Executive Committee for the coming year.

The new full-time director of the Atlanta Southside Comprehensive Health Center—formerly known as the Price Health Center—is **James A. Alford**. Dr. Alford is a member for the faculty at Emory University School of Medicine.

John Warkentin was a guest lecturer at the annual meeting of the American Academy of Psychotherapists in Chicago. At that same meeting, **Richard E. Felder** was elected vice-president of the Academy for 1969.

Mason I. Lowance has been named president-elect of the American Association for Clinical Immunology and Allergy.

Guest speaker for the Scoliosis Symposium at the Hospital for Joint Diseases in the Mt. Sinai School of Medicine in New York was **Darius Flinchum**.

Seventh District

John M. Covington of Dallas attended the Sixth Medico-Legal Workshop for Medical Examiners held

in Athens. Dr. Covington is Medical Examiner for Paulding County.

Tom Harbin of Rome has recently been elected Chairman of the House of Delegates of the American Association of Ophthalmology.

Tenth District

Alfred Jay Bollett of Augusta presented a paper at the recent meeting of the American Rheumatism Association held in Atlanta. The topic of Dr. Bollett's paper was "Can Osteoporosis Be a Collagen Disease? The Effect of Protein-Calorie Malnutrition on Bone Composition."

General practitioners attending a recent symposium at the Medical College of Georgia heard a talk by **James McCranie** concerning the diagnosis of neuroses.

Walter J. Brown has been named to head the physical medicine division of the University of Georgia's Health Services.

DEATHS

Eustace A. Allen

Atlanta physician Eustace A. Allen, 74, died December 7 as a result of injuries received in an automobile accident. Dr. Allen was a member of the staff at Emory, Georgia Baptist and Crawford Long hospitals, and a member of the medical faculty at Emory.

For 14 years, he served as a delegate to the American Medical Association and was vice president of the organization in 1961-62.

Dr. Allen was a former secretary and treasurer of the Fulton County Medical Society; former vice president of the Medical Association of Georgia, and was on the staff of the Tuberculosis Association and the Atlanta Community Chest. He also was a founder and chairman of the public relations committee of both the Fulton County Medical Society and the Medical Association of Georgia.

Survivors include his wife, two sisters, Mrs. H. S. Horton of Carrollton and Mrs. O. B. Farrell of Douglasville.

J. A. Combs

Atlanta area general practitioner, J. A. Combs, died November 13 at the age of 91.

A graduate of the Atlanta College of Physicians, now Emory University School of Medicine, Dr. Combs practiced in Locust Grove until 1923, and in Atlanta from 1923 until 1960. He was a member of the Fulton County Medical Association, the American Medical Association, the Medical Association of Georgia, and on the staff of Georgia Baptist Hospital.

Survivors include two daughters, Mrs. Janice Hughes of Decatur, and Mrs. Lois Kropa of Atlanta.

Victor Hugh McMichael

Victor Hugh McMichael of Macon died November 12 after a brief illness.

He received his degree from Emory University and served his internship in Lexington Hospital and Bellevue Hospital in New York City.

Survivors include his wife; two daughters, Mrs. Thomas Roger Messick of Williamstown, Mass., and Miss Ruth McMichael of San Diego; one brother, James Robert McMichael of Quincy, Fla., and several nieces, nephews and grandchildren.

Harold Wright Muecke

Harold Wright Muecke, 60, of Waycross, died October 26.

A native of Macon, Dr. Muecke received his M.D. degree from Vanderbilt University in 1935, and began private practice as a pediatrician in Waycross in 1939. In 1954 he was named president of Ware County Hospital, and served on the staff of Memorial Hospital and as consulting pediatrician for several area hospitals.

Dr. Muecke was president of the Georgia Pediatric Society in 1953-54 and a former president of the Ware County Medical Society.

Survivors include his wife; one daughter, Mrs. Keith Craddock of Atlanta; one son, Pvt. Harold W. Muecke, Jr. of Fort Sam Houston, Tex.; one brother, Henry G. Muecke, Jr. of Macon; one granddaughter, and several nieces and nephews.

Harry Young Righton

Harry Young Righton died November 12 at the age of 86.

He was former chief of staff at St. Joseph's Hospital in Savannah, a past president of the Georgia Medical Society, and a former mayor of Savannah. He received his medical degree from the University of Maryland, and later studied in Vienna.

Survivors include his wife; a son, Ralph V. Righton of Stone Mountain; a daughter, Mrs. A. V. Fonts of Brunswick; three sisters, Miss Eva L. Righton, Mrs. Joseph R. Weeks, Sr., and Mrs. J. B. Kieffer, all of Savannah; five grandchildren, and several nieces and nephews.

CALENDAR OF MEETINGS

In Georgia

- February 18-22, 1969—American College of Radiology, Regency-Hyatt House, Atlanta.
- February 23-26—Atlanta Graduate Medical Assembly, Regency-Hyatt House, Atlanta.
- March 6-7—Symposium on "Progress of Man Toward the Year 2000," Sponsored by the Cobb County Medical Society and Kennesaw Junior College, Kennesaw Junior College, Marietta.
- March 14-15—American Burn Association, Regency-Hyatt House, Atlanta.
- March 15—AMA Regional Workshop for State Chairmen of Committees on Medicine and Religion, Air Host Inn, Atlanta.
- March 27-29—Southern Society of Anesthesiologists, Marriott Motor Hotel, Atlanta.
- May 4-7—115th MAG Annual Session, Savannah Inn and Country Club, Savannah.

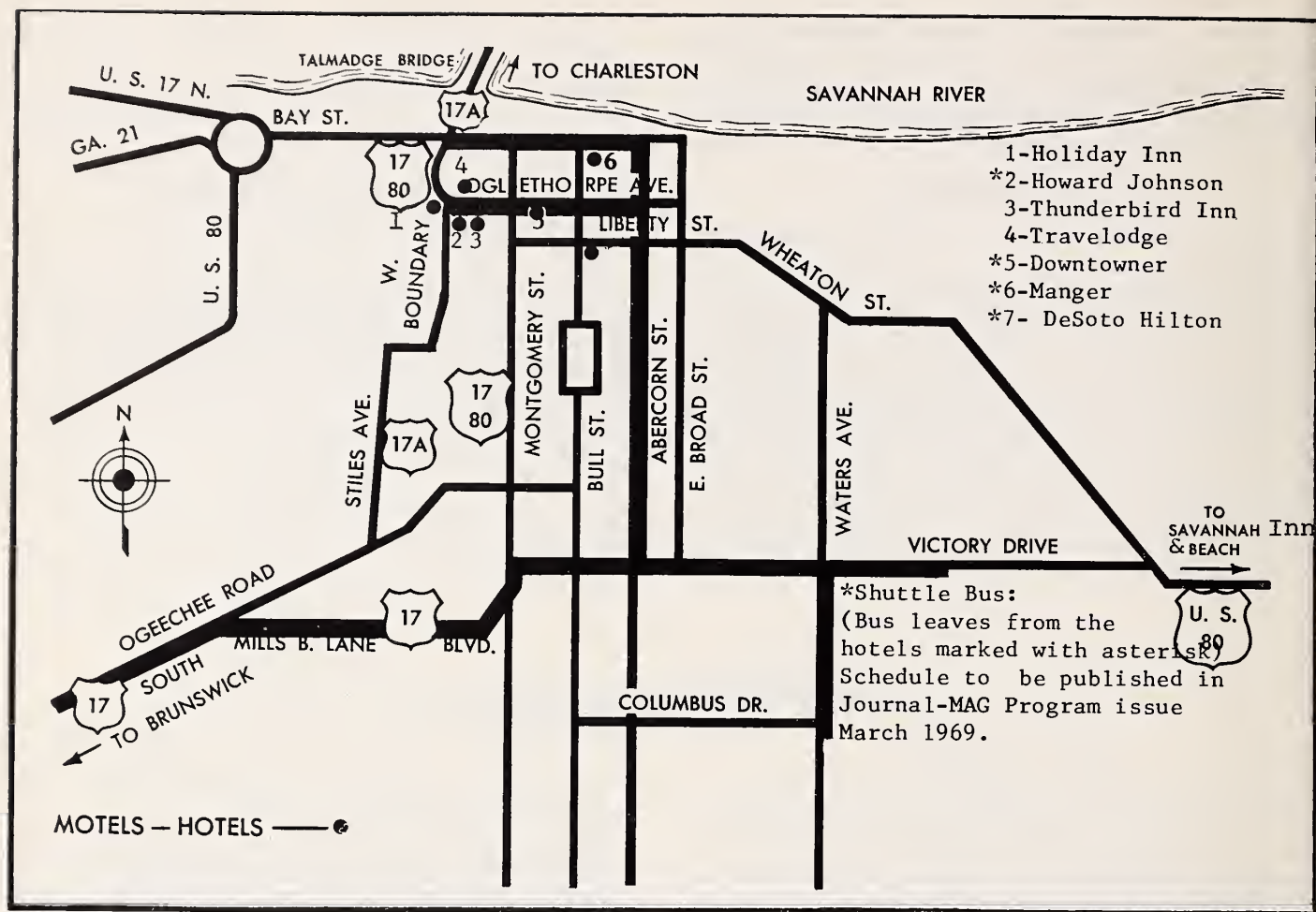
National

- January 18-23—American Academy of Orthopaedic Surgeons, Americana Hotel, New York, N.Y.
- January 22-24—Frontiers of Medicine 1969 (Sponsored by Lakeland Graduate Medical Assembly; co-sponsored by Staff of Winter Haven Hospital and Florida Academy of General Practice), Sheraton Motor Inn, Winter Haven, Fla.
- January 23-25—Southern Society of Clinical Investigation, Jung Hotel, New Orleans, La.
- January 31-February 2—Southern Radiological Conference, Grand Hotel, Point Clear, Ala.
- February 5-7—American Academy of Occupational Medicine, Sheraton Plaza Hotel, Boston, Mass.
- February 8-13—International Academy of Proctology (Annual Congress and Teaching Seminar), Hollywood Beach Hotel, Hollywood, Fla.
- February 9-10—Congress on Medical Education, Palmer House, Chicago, Ill.
- February 13-15—Society of University Surgeons, Hotel Fontainebleau, Miami Beach, Fla.

- February 20-22—Central Surgical Association, Drake Hotel, Chicago, Ill.
- February 24-26—American College of Surgeons, Sectional Meeting, Brown Hotel, Louisville, Ky.
- February 26-March 2—American College of Cardiology, New York Hilton, New York, N.Y.
- March 2-5—International Anesthesia Research Society, Americana Hotel, Bal Harbour, Fla.
- March 5-7—Symposium on Fundamental Cancer Research, "Genetic Concepts and Neoplasia," Shamrock Hilton Hotel, Houston, Tex.



Pictured above is Dub Wallace (left), MAG staff and Bill Weaver, M.D., member of MAG's Traffic Safety Committee in attendance at the Governor's Conference on Traffic Safety held in the House Chamber in Atlanta. The discussion centered around five bills on traffic safety which will be introduced in the General Assembly.



THE ANNUAL MEETING*—A MINI-SCHEDULE

Sunday, May 4, 1969

- 11:00 a.m.—Registration opens
- 12:00 noon—Auxiliary Pre-Convention Board Luncheon (DeSoto Hilton)
- 1:00 p.m.—General Business Meeting
- 2:30 p.m.—Specialty Society Meetings
- 6:00 p.m.—Specialty Society Receptions and Dinners

Monday, May 5, 1969

- 9:00 a.m.—Second General Business Meeting
First Session of House of Delegates
- 2:00 p.m.—Scientific Sessions
- 6:00 p.m.—Alumni Receptions and Dinners

** Note: Unless otherwise indicated all functions will be held at the Savannah Inn and Country Club.*

Tuesday, May 6, 1969

- 9:00 a.m.—Reference Committees Meetings
Auxiliary General Meeting
(DeSoto Hilton)
- 12:00 noon—Auxiliary Luncheon (DeSoto Hilton)
- 2:00 p.m.—Scientific Sessions
- 7:00 p.m.—MAG Annual Reception and Banquet

Wednesday, May 7, 1969

- 9:00 a.m.—Third General Business Meeting
Second Session of House of Delegates
- 12:00 noon—Adjournment

Special shuttle buses will connect the MAG Headquarters Hotel, The Savannah Inn and Country Club, with the Auxiliary Headquarters Hotel, The DeSoto Hilton Hotel, and other major motels for the convenience of those attending the MAG meetings.

CALL FOR SCIENTIFIC EXHIBITS

115TH ANNUAL SESSION OF THE MEDICAL ASSOCIATION OF GEORGIA

Savannah, Georgia, May 4-7, 1969

For Information and Applications, Write:

John McClure, Jr., M.D., Chairman, MAG Scientific Exhibits Committee
938 Peachtree Street, N.E. • Atlanta, Georgia 30309

For Your MAG 1969 Annual Session

Hotel and Motel Reservations

APPLICATION FOR HOTEL AND MOTEL ACCOMMODATIONS

Medical Association of Georgia, 115th Annual Session
May 4-7, 1969—Savannah, Georgia

A HOUSING BUREAU has been established for your convenience in making hotel and motel reservations at Savannah for the 1969 Annual Session of the Medical Association of Georgia. Comparable room rates and accommodations information are listed. *Use the Reservation Form below.* Please specify your first, second and third choice. All requests should give anticipated date and hour of arrival; date and approximate hour of departure; names and addresses of all persons who will occupy the accommodations. All reservations must be cleared through the Georgia Medical Society, 612 Drayton Street, Savannah, Georgia 31401. Since all requests for rooms will be handled in chronological order, you should mail your application as early as possible, in order to be certain of obtaining your primary choice. All reservations will be confirmed.

***Desoto Hilton:** Liberty at Drayton Streets (232-0171). Woman's Auxiliary Headquarters. Rates: Single, \$13 to \$18; Double, \$17 to \$22; Suites, One Bedroom, \$38 and up, Two Bedrooms, \$56 and up. 260 Rooms.

***Manger Hotel:** Bull at Congress Streets (232-6121). Rates: Single, \$10; Double, \$15; Extra person in room, \$3 each. 100 Rooms.

***Downtowner Motor Inn:** 201 W. Oglethorpe Avenue (233-3531). Single, double bed, \$11 for one person—\$13 for two. Double, 2 double beds, \$12 for one; \$15 for two. Suites, \$25 and up. No charge for children using same accommodations as parents. 65 Rooms.

Holiday Inn: 121 W. Boundary Street, on U. S. No. 17 at Talmadge Bridge (236-1355). Single, one person \$10; two persons, \$13; Double, one person, \$13, two persons \$15. 75 Rooms.

***Howard Johnson's:** 224 West Boundary Street, on U. S. Highway No. 17-A, at Talmadge Bridge (232-4371).

Single, \$12 to \$14; Double, \$14 to \$17 and family rates. 60 Rooms.

Savannah Inn and Country Club: Wilmington Island (897-1612). Headquarters Hotel for meetings, exhibits, social functions, and housing for Council, officers, Staff, Guest Speakers and Delegates as chronologically requested. Shuttle bus will connect with other major hotels. **Modified American Plan** (breakfast and dinner). Single, \$22 to \$29; Double, \$29 to \$44; Suites, \$46 and up. 160 Rooms.

Thunderbird Inn: 611 W. Oglethorpe Avenue on U. S. No. 17 at foot of Talmadge Bridge (231-2661). Single, \$9; two persons, \$12; Double, \$12 and \$14. 20 Rooms.

Travelodge: 512 W. Oglethorpe Avenue, Talmadge Bridge, off U. S. No. 17 (233-9251). Single, \$10, two persons, \$13; Double, \$9 for one person, \$11 for 2 persons: \$2 for each additional person. 20 Rooms.

Confirmation of your request for accommodations will be in accordance with preference indicated, if possible; if not, best substitutes will be made.
*Shuttle bus will operate from this hotel to Savannah Inn and Country Club. Schedule will be published in March 1969 issue of JOURNAL MAG.
If you wish to stay at Tybee Beach, please indicate on reservation form and Housing Bureau will arrange.

Cut out and send to:

Please type or print

HOUSING BUREAU, MEDICAL ASSOCIATION OF GEORGIA

612 Drayton Street, Savannah, Georgia 31401—Attention: Mrs. Lee Giffen

Please reserve the following accommodations for the 1969 Annual Session of the Medical Association of Georgia:

Hotel or Motel Preference

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2nd Choice ☐ Double Room at \$ to \$
3rd Choice ☐ Twin Bedroom at \$ to \$
..... ☐ Other type

Arrival Date Hour A.M. P.M.

Departure Date Hour A.M. P.M.

THE NAME OF EACH HOTEL GUEST MUST BE LISTED. Include all names of all persons for whom you are requesting reservations and who will occupy space.

Name of Occupant(s)

Address

Individual Requesting Reservations

Name

Address

City State

Zip

If hotels or motels of your choice are unable to accept your reservations, the Housing Bureau will make reservations to fit your specifications elsewhere.

HIGHLIGHTS OF EXECUTIVE COMMITTEE OF COUNCIL MEETING, NOVEMBER 17, 1968—ATLANTA

This summary is being published so that members may be advised of the actions of the Executive Committee between meetings of Council. It covers only major actions and is not intended as a detailed report in lieu of meeting minutes.

FLEX Examination—Dr. Haverty reported that the Board of Medical Examiners would seek a statutory change in the Medical Practice Act that would permit it to administer the FLEX exam to candidates for licensure as physicians in Georgia. The Board would retain its right to make additional requirements of candidates for licensure. The Executive Committee endorsed this request as sought by the Board.

Payment Method for Salaried M.D.'s Under Title XIX at Grady Hospital—The Committee heard a report from Dr. Joseph Wilson, Title XIX Committee Chairman, concerning the method of payment of full-time salaried physicians rendering services to Medicaid patients at Grady Hospital. The Committee then approved a letter to be sent to Dr. Venable in response to his request, the substance of which is as follows: "Require that payments for services rendered by physicians who are paid a salary to supervise a professional program of medical education be made only on a cost basis, i.e., as part of hospital allowable cost, subject to

audit and adjustment at the end of an accounting period." The approved letter further makes clear that MAC is directing its remarks solely at Grady Hospital at this time.

Osteopathy—The Committee received a memorandum prepared by Mr. W. B. Spann, MAG Legal Counsel, forming the basis for negotiations between MAC and the Osteopathic Association on the question of a composite board of examiners. The Committee approved in principle this memorandum and instructed staff to explain to Mr. Spann certain changes which should be made.

Continuing Medical Education—Received for information and consideration at December Council a suggestion by Dr. Haverty that MAG consider the employment of a full-time staff employee to have responsibility for continuing medical education.

Non-Dues Paying Membership—The Committee approved a proposal that a classification of non-dues paying membership be created for medical students, interns and residents to permit them to take advantage of the MAG insurance benefit package, and referred the matter to the Constitution and Bylaws Committee.

Finance Report—The Committee approved the projected 1969 budget as presented by the Finance Committee and referred it to December Council.

Hill Crest HOSPITAL

(Formerly Hill Crest Sanitarium)

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Both male and female pa-

tients are accepted and departmentalized care is provided according to sex and the degree of illness.

In addition to the psychiatric staff, consultants are available in all medical specialties.



MEDICAL DIRECTOR:
James A. Becton, M.D.

CLINICAL DIRECTORS:
James K. Ward, M.D.
Hardin M. Ritchey, M.D.

HILL CREST is a member of:
AMERICAN HOSPITAL ASSOCIATION . . .
NATIONAL ASSOCIATION OF PRIVATE PSYCHIATRIC HOSPITALS . . .
ALABAMA HOSPITAL ASSOCIATION . . .
BIRMINGHAM REGIONAL HOSPITAL COUNCIL

Hill Crest is fully accredited by the Joint Commission on Accreditation of Hospitals.

Hill Crest
HOSPITAL
BIRMINGHAM, ALABAMA

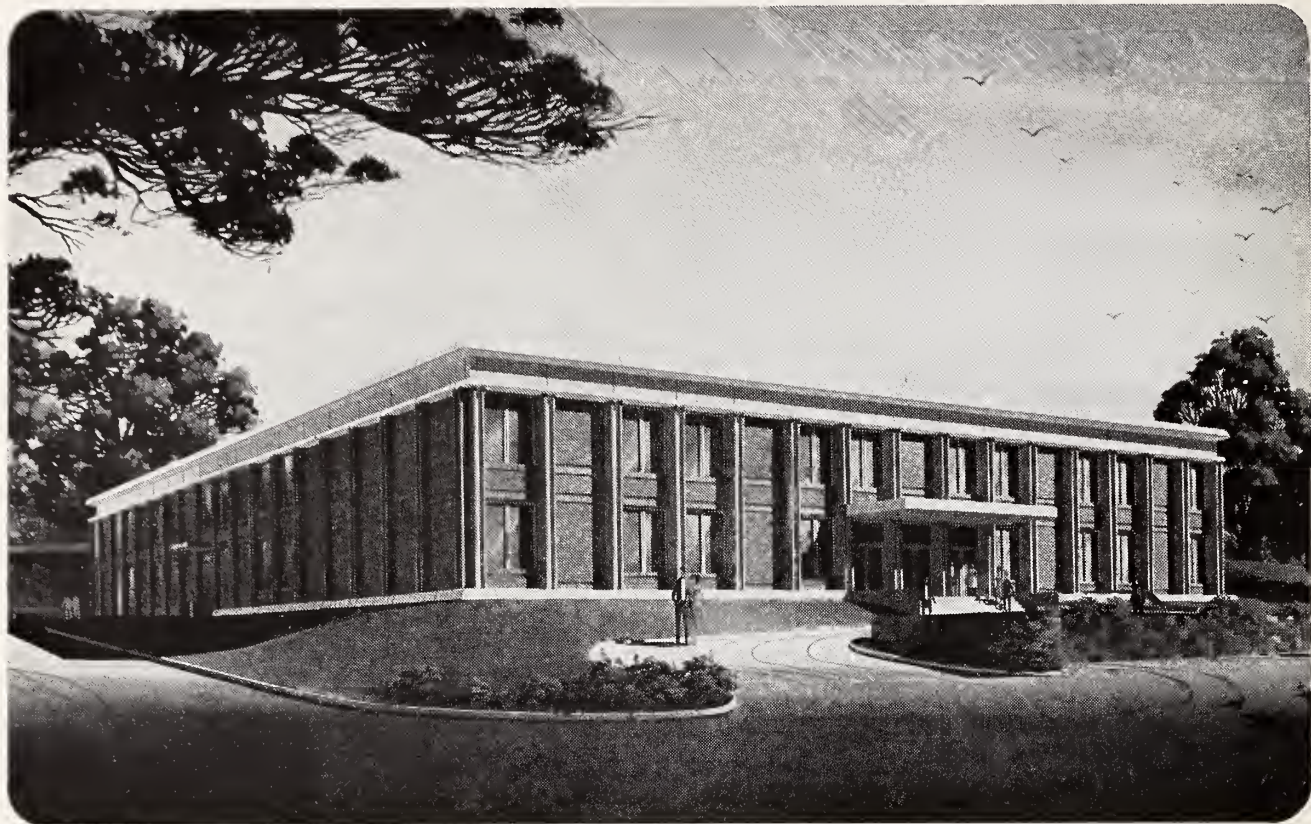
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GEORGIA REGIONAL MEDICAL PROGRAM



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New, Long-term Psychiatric Facility

The new forty bed Parkwood Hospital specializes in long-term treatment of the mentally ill. Under the direction of a Medical Director, the hospital facilities are available to over thirty psychiatrists who are on its staff. Parkwood provides a full complement of exceptional facilities including X-ray, laboratory, pharmacy, occupational and music therapy, patient beauty parlor and an outdoor recreational area. □ Special efforts were made to combine maximum patient comfort with a warm, secure, residential atmosphere readily conducive to psychotherapy. □ We will be pleased to provide further information upon request.

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(In vivo measurement of Lutrexin on contracting
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Cover

Grand Rounds at Grady Hospital conducted by John Stone, M.D., Chief Medical resident, being televised and transmitted live to receiving hospitals via GRMP television network. Design by Mr. Ike Hussey, Higgins-McArthur, Longino & Porter, Atlanta.

The Impact of GRMP Operational Projects on Hospitals and Physicians in Georgia

IN JULY OF 1968, the Georgia Regional Medical Program was awarded \$1.4 million in operational funds by the U.S. Public Health Service for the first of a three-year program.

The grant monies were requested to underwrite 14 projects designed to make available the best possible patient care for heart disease, cancer, stroke and related diseases. Under the leadership of Dr. J. Gordon Barrow, GRMP Director, and Dr. Robert R. Smith, GRMP Associate Director, along with Staff Coordinators and Project Directors, the Program has progressed rapidly. As the projects get underway, they move the Georgia region closer to its goal of spreading improved medical care in the region through the coordinated efforts of all health resources.



Richard E. Morrison, Consultant with Massachusetts Research and Management Firm, consults with Dr. Smith, Mrs. Elsie Brown (GRMP Administrative Assistant), and Dr. Barrow on approach GRMP is taking to Regional needs and problems.



Dr. Robert R. Smith, GRMP Associate Director, and Dr. J. Gordon Barrow, GRMP Director, review progress of 14 operational projects.



Field Staff under direction of Bill Wilkins, covers Region as liaison to Local Advisory Groups and Project Directors.

GRMP / Continued

Following are summaries of the progress to date of these initial projects.

Practicing Physicians Postgraduate Courses

The special postgraduate clinical training conferences offered by both Emory and the Medical College are arousing a great deal of interest among practicing physicians throughout the State.

Through this program, physicians are given an opportunity to return periodically to a teaching institution to participate in new types of educational activity. Special clinical training also provides new skills in diagnosis and treatment that will aid physicians in bringing the latest results of research in cardiovascular diseases to patients as rapidly as possible. Physicians actively participate in the management of patients under the supervision of the medical school faculty.

Courses at Emory

Five courses are being offered by the Emory University School of Medicine, Atlanta:

(1) *General Cardiology*

The curriculum includes:

- Didactic lectures
- Cardiac rounds
- General medical ward rounds of the Department of Medicine
- Attendance at medical conferences
- Participation in cardiac clinics
- Work and study in the medical library
- Attendance at medical conferences involving cardiac surgery, pediatrics and medicine.

(2) *Management of Coronary Care Units and New Approaches to the Treatment of Myocardial Infarction and Its Complications*

The curriculum includes:

- Didactic lectures on appropriate subjects such as electrocardiography, cardiovascular physiology and pharmacology
- Exercise in identifying unknown electrocardiograms
- Observation and actual work under supervision in an active coronary care unit.

(3) *Hypertension and Renal Disease*

The curriculum includes attendance at the following:

- Morning report and disposition rounds of the Renal Service
- Lectures on the physiology and pathology of the kidney and circulation

- Noonday medical conference presented twice a month by the Renal Division
- Supervised participation in the Renal Hypertension Clinic
- Renal conference and Seminar of the Renal Division.

(4) *Cerebral Vascular Disease: Diagnosis, Treatment and Rehabilitation*

The curriculum includes:

- Didactic lectures
- Ward rounds
- Demonstrations of equipment
- Techniques of physical rehabilitation
- Practical exercises in neuroradiology and neuropathology.

(5) *Advanced Electrocardiography*

The curriculum includes:

- Didactic lectures
- Exercise in identifying diagnoses upon presentation of electrocardiograms without clinical data
- Supervised practice in reading electrocardiograms.

Each course is being given one day a week for 12 weeks—two to four times a year—with up to four trainees accepted per course. Starting dates can be flexible to fit the physician's schedule.

Faculty includes: Bernard L. Hallman, M.D.; J. Willis Hurst, M.D.; Elbert Tuttle, M.D.; and Herbert Karp, M.D.

Courses at Medical College

Four courses are being offered by the Medical College of Georgia, Augusta:

(1) *Coronary Artery Disease*

The purpose of the course is to acquaint the practicing physician with the newer methods of diagnosis and management of acute and chronic coronary artery disease.

The curriculum includes:

- Monitoring procedures
- Coronary care units
- Resuscitation
- Cardiogenic shock
- Arrhythmias
- Management of heart block.

(2) *Clinical Cardiology and Electrocardiography*

The purpose of the course is to provide an extensive supervised experience in electrocardiography and general cardiology. Half-day electrocardiography will be followed by side by side work with cardiologists in special clinics.

(3) *Pediatric Cardiology*

Course is offered specifically as program in congenital heart disease and rheumatic fever.

The curriculum includes:

- Clinical diagnosis
- Electrocardiographic interpretation
- Radiographic interpretation



Dr. James Achord (right), Emory Professor of Gastroenterology, discusses use of special equipment with Dr. Harry Brill (center), Columbus Internist, who is participating in GRMP's Clinical Training Conferences for Practicing Physicians. Director of the project at Emory, Dr. Bernard Hallman, looks on.

- Methodology of laboratory diagnosis including cardiac catheterization and angiography
- Etiologic factors including basic genetic studies and parent counseling.

(4) *Technics of Cerebral and Cardiovascular Angiography*

The purpose of this course is to teach radiologists the fundamentals of modern techniques of cerebral and cardiovascular angiography.

Courses 1 and 2 are being offered one day a week for 12 weeks—three times a year—with a maximum of four students per course; course 3 is being offered one day a week for six weeks—four times a year—with a maximum of four students per course; and course 4 is being offered six days a week for two weeks—four times a year—with a maximum of two students per course. Starting dates are also flexible to fit the physician's schedule.

Faculty includes: Raymond P. Ahlquist, Ph.D.; A. Calhoun Witham, M.D.; Gerald Holman, M.D.; and Mark Brown, M.D.

Dr. Bernard Hallman, Associate Dean at Emory and Coordinator of GRMP projects at that institution, says:

"The practicing physicians' postgraduate courses are turning out to be one of the most popular projects that the medical school is sponsoring co-operatively with the Georgia Regional Medical Program. At first we thought that the faculty might feel a bit imposed on by having this extra duty in addition to their regular duties of teaching the interns and residents and medical students. However, we find that this is not the case. The doctors who come here from the other communities are excellent physicians themselves and, whether they know it or not, they are contributing a great deal toward the teaching program. They are asked to participate on ward rounds and in medical conferences and they frequently get up and make comments or give some side of the subject under discussion that wouldn't have been thought of otherwise. It also seems to stimulate the professors, especially the young professors, to have the older practicing physicians in the audience or in the ward round group.

Overwhelming Response

"I have been overwhelmed by the response of the practicing physicians applying for the short courses. A few days ago, we received a telephone call from a general practitioner in North Georgia who had been reading the brochure. His opening remarks were, 'I just want to find out if this is a misprint. This sounds too good to be true.' He just couldn't believe that he



Dr. Achord and Dr. Brill consult with patient in outpatient clinic at Grady Memorial Hospital.

could come down here one day a week and do postgraduate work and even have his automobile expenses paid at the rate of eight cents a mile.

"He told me over the phone that he wanted to take all five courses in the series and that he planned to come one day a week for the next two or three years. Later when this man's credentials arrived, we found that he was one of four general practitioners in a small community and that one of the other general practitioners had gotten interested in the

GRMP / Continued

program and they were going to swap days so that one could come on Wednesday and one on Thursday. Both of them had only had a rotating internship and felt very badly the need to increase their knowledge in cardiovascular disease especially. But they were also interested in the stroke program and early cancer rehabilitation program.

"On many of the cards and letters of application, the doctors have said, 'I would like to take all five courses, and am particularly interested in four of them.' They are also having difficulty deciding which one to go into first. This enthusiasm, of course, has been contagious, and the faculty is just as excited about it as the doctors in the communities are.

"All of this led me recently to write a letter to the Dean of the Medical School and also to the Department Chairmen, pointing out that certainly as a method of postgraduate education we had been neglecting this, and should immediately begin to strengthen all of our programs and try to broaden this aspect. This seems to me to be the most effective of any form of postgraduate education."

Dr. Raymond Ahlquist, Associate Dean of the Medical College and Coordinator of GRMP projects at that institution (Dr. Ahlquist is also Secretary of the Regional Advisory Group and a member of the Steering Committee) reports that response to the courses being offered there is also quite good.

Between the two schools, approximately 25 applications have now been received.

Post-Residency Traineeships in Pediatric Cardiology and in Hypertension-Renal Disease

One-year traineeship programs for physicians in pediatric cardiology and in hypertension-renal diseases will be offered at both medical schools beginning in July, 1969. These programs will be supervised at Emory by Drs. Elbert Tuttle and Kathryn Edwards, and at the Medical College by Drs. Gordon Folger and James Hudson.

At Emory, the Pediatric Cardiology Program will be under the immediate direction of three full-time faculty members in the Department of Pediatrics.

Upon completion, trainees will have experience in diagnosis and management of cardiovascular problems of both in- and out-patients and in preoperative and postoperative care of infants and children having cardiac surgery. Special attention will be directed to: pathophysiology, heart failure, cardiac function and congenital heart disease; pharmacology of drugs used in pediatric cardiology; and pathology of heart disease.

Supervised instruction will be provided in: electrocardiography, vectorcardiography, phonocardiogra-

phy, X-ray procedures (including arteriography and angiocardiology), blood gas studies and acid-base balance.

Activities will include: techniques and interpretation of special studies (EKG, VCG, cardiac catheterization, and angiocardiology); clinical care and consultations on wards; rounds with staff; conferences (basic principles of hemodynamics, pathology, medical-surgical disposition, radiology, electrocardiography); and outpatient clinic (pediatric cardiac) teaching. Qualifications include: Two years completion of pediatric training.

Clinical Training in Pediatric Cardiology at the Medical College will be centered in the clinical activities of the Division of Pediatric Cardiology under the direction of Dr. G. M. Holman.

Activities will be centered at the Eugene Talmadge Memorial Hospital, a 500-bed State-supported institution.

The program will be designed to provide training in the field of congenital and acquired heart disease in children. Training will be through care of patients on the hospital wards, out-patient tests and procedures and regular clinical and basic science conferences concerning the specialized aspects of the child and his disease. Emphasis will be placed on diagnostic studies used in routine clinical examinations, including electrocardiographic and radiologic evaluation and interpretation.

Areas of particular emphasis which will be developed through a series of conferences and seminars include: evaluation of the sick newborn infant, appreciation of acid-base changes in the young infant, and a clearer understanding of the appropriateness of time and relationship to surgical intervention.

Qualifications include post-doctoral candidacy and two years clinical pediatric experience.

Hypertension-Renal Disease Program

Trainees in the Emory Hypertension-Renal Disease Program will be an integral part of the Renal and Electrolyte Division of the Department of Medicine and will serve as primary physicians for patients on the service and see in consultation patients of other physicians in the hospital.

The training program will include: supervised specialty rounds, consultation on ward rounds at Grady Hospital, assisting in the Atlanta Artificial Kidney Center, and Clinical Fellowship at Emory Hospital and Clinic and/or Atlanta Veterans Administration Hospital. Trainees will participate in the care of kidney transplant patients and will have the opportunity to observe urological procedures.

Studies will be provided in: kidney biopsy, peritoneal and hemodialysis, renal vein and artery cath-

terization, renin assay, and physiological function tests of circulation and kidneys.

Qualifications include completion of internship, and interest in renal and hypertensive disease.

The traineeship in hypertension and renal diseases at the Medical College will be centered around the clinical activities of the Renal Disease and Hypertension Divisions of the Department of Medicine. Major emphasis will be at the Eugene Talmadge Memorial Hospital and at the affiliated Veterans Administration Hospital.

Supervised training will be provided in: in-patient care on the hospital wards and in out-patient clinics, special diagnostic tests and procedures, regular clinical basic science conferences, and specialized treatment procedures.

Special diagnostic and therapeutic procedures will include: differential angiography, blood renin and pressor activity assays, renal biopsy, and peritoneal and hemodialysis.

Through conferences and seminars designed to complement clinical activities, emphasis will be placed on the following areas: evaluation of the urine sediment and the interpretation of renal tests; technique and applications of renal biopsy; identification of remedial forms of hypertension; pathophysiology, clinical analysis and treatment of acid-base, electrolyte and fluid balance disturbances; use of steroids and immuno-suppressive agents in the treatment of renal disease and control of homograft rejections; natural history of hypertensive and renal diseases and the clinical and metabolic consequences of uremia; effective use of conservative and dietary treatment schedules in chronic renal failure; familiarity with appropriate clinical laboratory equipment and procedures, theoretical and practical aspects of peritoneal and hemodialysis in acute renal failure; preventive medicine in hypertensive and renal diseases; restrictions imposed on general medical treatment by accelerated hypertension and uremia.

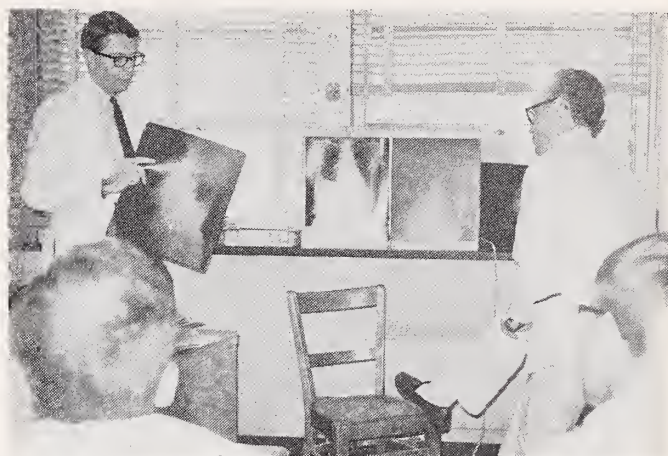
Qualifications include post-doctoral candidacy, and two to three years clinical experience.

Visiting Consultants to Community Hospitals

Professional consultants in the areas of interest to GRMP are now available to community hospitals as another service of the Program. Faculty members from both Emory and the Medical College, as well as specialists in private practice, can be scheduled for consultation with either physicians, nurses or allied health professionals.

These visiting consultants will see problem patients, make ward rounds, participate in case conferences, in-service education and in all other ways in the continuing education programs of the hos-

pital. All expenses will be underwritten by GRMP. A number of specialists in private practice have already indicated an interest in participating in the program, and several have been scheduled.



A Visiting Consultant participates in a case conference with the hospital staff.

Hospitals can request visiting consultant services by contacting: for Emory faculty—Bernard L. Hallman, M.D., Associate Dean, Emory University School of Medicine, 69 Butler Street, S.E., Atlanta, Georgia 30303; for Medical College faculty—Raymond P. Ahlquist, Ph.D., Associate Dean, Medical College of Georgia, Augusta, Georgia 30902; for other sources—J. Gordon Barrow, M.D., Director, Georgia Regional Medical Program, 938 Peachtree Street, N.E., Atlanta, Georgia 30309.

Medical Library Services for Hospitals

Medical librarians from throughout the State attended an Institute for Hospital Librarians sponsored by GRMP in December in Atlanta. The subject of the Institute was the expanded interlibrary loan and photocopying services of Emory's A. W. Calhoun Medical Library and the Medical College's Library which are designed to provide more adequate library support of medical education, medical research and medical practice in Georgia and result in faster, more efficient service.

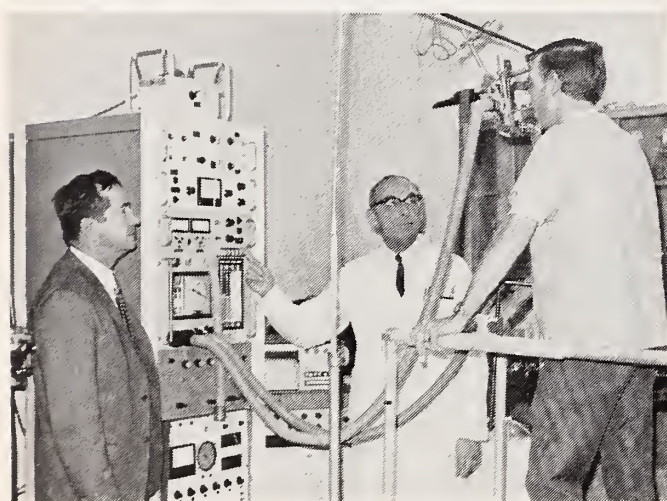
Through these increased services, all current articles and reference materials of the two medical school libraries, as well as other sources, are now available to physicians and other health professionals through their local hospital libraries.

Librarians attending the Institute were informed of the expanded services and instructed in interlibrary loan procedures such as acquisition, cataloging, binding, serials, and reference and bibliographic services.

In addition to lending original material, the two libraries now fill requests from GRMP participating institutions with free photocopy when feasible.



(Above) Medical Librarians Workshop, Atlanta, December 12, 1968, was sponsored by GRMP. (Below) Dr. Ross McLean (center), Professor of Medicine (Pulmonary Disease) at Emory, demonstrates equipment to Dr. McLeod Patterson, Director of Medical Education at the Columbus (Ga.) Medical Center, as a part of the Affiliation for Teaching Project sponsored by GRMP.



During the first year each institution may request a maximum of 3,000 pages and may allocate these pages to the local staff as it deems suitable. Institutions not participating in GRMP will pay a minimum charge for photocopies.

To facilitate interlibrary borrowing, the medical school libraries will produce and distribute a list of their periodical holdings; these lists will be updated periodically. Requests for books and journals they do not own will be forwarded to an appropriate source at no charge to the borrowing library.

Requests for services must be submitted through a hospital library on standard interlibrary loan request forms or in standard teletypewriter (TWX) format. Libraries should not request photocopies of materials available locally.

Mrs. Miriam Libbey is coordinator of the project at Emory and Miss Sadie Rainsford at the Medical College. Both Mrs. Libbey and Miss Rainsford report several hundred requests since the project was announced. Hospital libraries and physicians are encouraged to make full use of these expanded services.

Columbus Medical Center-Emory University Affiliation for Teaching

Seven Columbus physicians have received clinical appointments to the faculty of Emory's School of Medicine for the purpose of organizing and administering a continuing medical education program for interns, residents and physicians at The Medical Center—a community hospital in Columbus. This is a pilot project of GRMP.

Coordinators of the Columbus project are Dr. Bernard Hallman, Associate Dean at Emory, and Dr. McLeod Patterson, Medical Director of The Medical Center.

The Emory faculty appointments include the chiefs of the various services at The Medical Center: Dr. Patterson, Clinical Associate Professor of Preventive Medicine and Community Health; Dr. Jack W. Hirsch, Clinical Assistant Professor of Medicine; Dr. Richard M. Shuffstall, Clinical Assistant Professor of Pathology; Dr. Mary W. Schley, Clinical Assistant Professor of Pediatrics; Dr. Peter C. Graffagnino, and Dr. Hugh J. Bickerstaff, Clinical Assistant Professors of Gynecology and Obstetrics; and Dr. William G. Love, Jr., Clinical Assistant Professor of Surgery.

The objectives of The Medical Center's teaching program are: (1) to assure the highest quality medical care in Columbus and the surrounding area through the continuing education of all physicians; (2) to improve the postgraduate training of interns and residents; and (3) to attract additional well-qualified physicians to practice in the Columbus area.

During the first year, physicians from Columbus who qualify for the program will spend a minimum of two weeks' time at Emory's medical school in prescribed studies. Each participating physician will also devote a specified number of hours weekly to the training.

The first group of Columbus physicians was selected by their colleagues of the Muscogee County Medical Society to get the program underway, Dr. Hallman said. Other Columbus physicians are expected to be added to the Emory clinical faculty at The Medical Center after the first year's operation, he added. He explained that such appointees must meet the same educational standards as the regular Emory medical faculty. New faculty appointments will be made on an annual basis.

Thirty-six Columbus physicians have enrolled in the program since it began September 1. The new program is open to all members of the Muscogee County Medical Society regardless of hospital affiliation, Dr. Hallman said.

Communications Network

The GRMP Television Network Project has let contracts for the installation of videotape recording and playback systems in 33 hospitals of over 100 beds throughout the State. (An additional six hospitals will be added by July.) Installation is expected to be completed in March. Initial program transmission got underway January 25. All hospitals of over 100 beds are eligible to participate in the Project.

Programs will be produced by the Community Medical Television System, based at Grady Hospital (Emory's teaching hospital) in Atlanta, and by the

Health Communications Department at the Medical College in Augusta. Joseph Staton, Director of the CMTV System, will coordinate the program at Emory, and Dr. James Sutherland is directing activities at the Medical College. Transmission will be through the facilities of the Georgia Educational Television System and programs will be initially taped by the hospitals on Saturday afternoons for playback at scheduled medical conferences.

Primary Objective

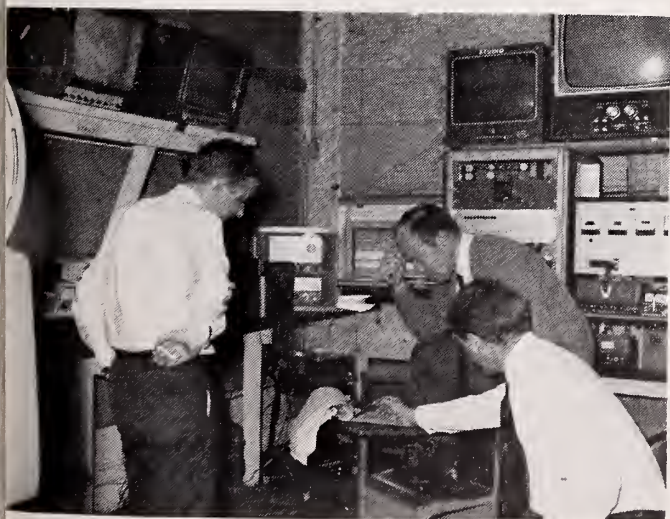
The primary objective of this project is to improve standards of patient care by providing physicians and nurses continuing access to postgraduate educational programs and by disseminating the knowledge gained through health sciences research for application to patient care. Topics will be selected on the basis of filling the needs for current knowledge, as well as reviewing practical information and procedures that may be applied in daily practice.

Along with an increased emphasis on programs dealing with heart disorders, cancer, and stroke, the Network will explore the application of teaching methods and objectives developed through educational science. Plans are underway to investigate new methods of using television and other media more effectively for physician and nurse education.

An institute for hospital and health professionals was held recently in Athens to assist in achieving maximum effective utilization of the GRMP Communications Network and to discover needs and problem areas. The project directors together with the GRMP staff are developing evaluation criteria and questionnaires through which baseline data can be obtained and an on-going plan for evaluation can be initiated.

Dr. Luther Fortson, Chairman of the Local Advisory Group at Kennestone Hospital in Marietta, where the project's first videotape recorder was installed, had this to say about the effect of the project on the staff:

"We are really quite excited about the implications of these educational television programs, for now we play back taped programs at two weekly early morning sessions and we run them twice—once at seven and again at eight. The Tuesday morning program is slanted toward the internists, and the Friday morning programs we slant toward the surgeons. The material we have recorded so far is material we have taken directly off the air from the CMTV Network and I have been functioning as a committee of one, more or less, in selecting the material we choose to replay on these morning sessions. We are endeavoring to spread the word as far as we can to include nurses and technicians as well as physicians, in order to get as much utilization from this as we possibly can.



Shown left to right in a TV Production Conference at the Medical College of Georgia are Doug Irskine, videotape engineer; Dr. Joseph Hollowell, Director of Birth Defects Center, and Timothy Prynne, Producer-Director for all programs at the Medical College for the GRMP Communications Network.

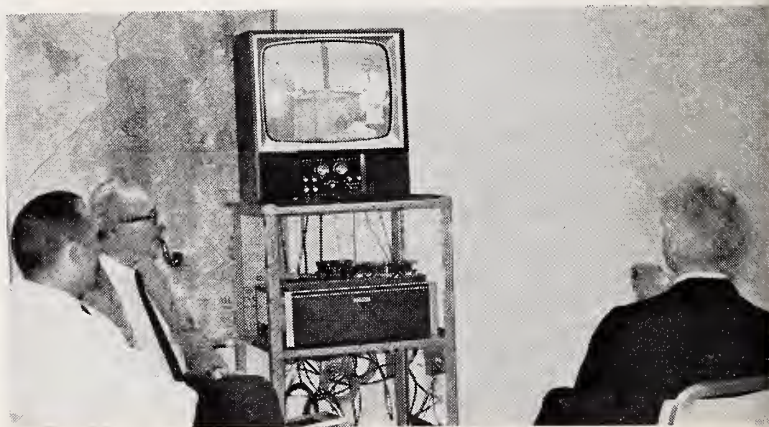
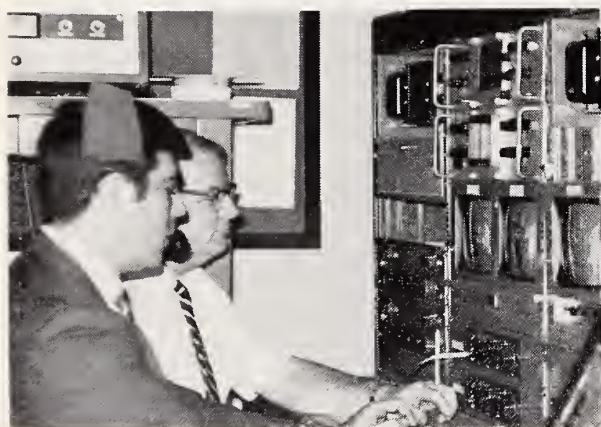
Enthusiastic Staff Response

"Response has been quite enthusiastic. Of course, we began prior to the holidays and we are really in our infancy now. It will take some time, I know, to make this a habit so that people will remember to come on these particular days as a matter of routine. But we are being patient—we feel it will roll as time goes on. Our utilization really has exceeded our expectations at the present time. We have only had our recorder in operation since the latter part of November or first of December.

"We are now exploring the possibility of hiring a technician who can be on duty in the evenings and

who could provide custom showings, more or less, for any staff member who would like to see particular programs at a time other than the regular schedule. We hope to maintain a library of tapes that we will update each week when the Statewide transmissions begin. We are already preserving a number of tapes. Several in fact, from the Emory University course on Cardiology for Nurses will be utilized by the nurses in our intensive care unit, such as programs on arrhythmias, pathology, the cardiovascular system—this sort of thing—slanted particularly toward nurses.

"We have found this so far to be an excellent teaching and continuing education tool. We are now planning on what we can do in the future and how to build up our resource material and of course,



(Top, left) Console at CMTV where programs are transmitted to statewide GRMP Television Network via ETV System. (Right) Dr. Luther Fortson, Chairman of the Local Advisory Group at Kennestone Hospital, Marietta, and other members of the Medical Staff watch a program recorded earlier from the CMTV network. The playback tape recorder is beneath the monitor on the mobile table. (Below) Dr. Fortson leads a discussion at a TV Conference for the Nursing Staff at Kennestone, using programs taped from the GRMP Communications Network.

the recorder supplied by GRMP is the essential link in the whole apparatus."

Improvement and Coordination of Cardiovascular Diagnostic Service Facilities

Facilities for providing cardiac catheterization services on referral from physicians presently exist in only five centers and three geographical areas of the State. Atlanta has laboratory facilities at Emory University Hospital, Grady Memorial Hospital and St. Joseph's Infirmary. Augusta has facilities at the Medical College of Georgia and the Memorial Center in Savannah is in the process of establishing a cardiovascular laboratory. Services at the present facilities, in addition to cardiac catheterization, include angiography and coronary angiography.

It is the plan of GRMP to strengthen present centers to handle the increasing case load and to train more medical and paramedical personnel in the field in order that these services can be provided to other hospitals in the Region.

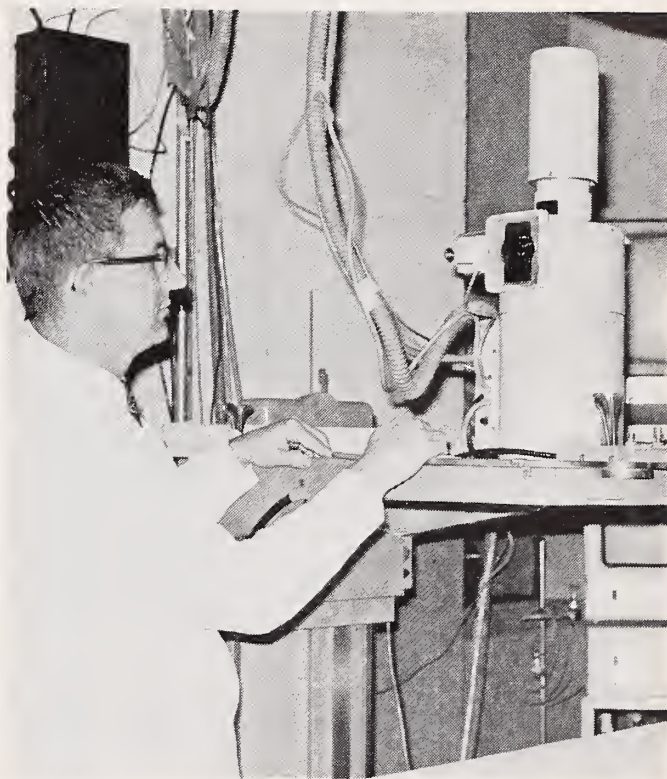
It is felt that because of the recent advent of interest in coronary artery disease and development of coronary cine arteriography, revascularization surgery will flourish in ensuing years. Therefore, all cardiovascular laboratories should be equipped so that each could move into coronary arteriography as skilled personnel are available.

This project is being centered for the first year at Emory, with later anticipated expansion to include the other labs around the State. Co-Directors at the Emory lab are Drs. Robert Franch, H. S. Weens, and Robert Schlant, all of the medical school faculty.

Cardiopulmonary Resuscitation Program

A Cardiopulmonary Resuscitation Program already established by the Georgia Heart Association and the Georgia Department of Public Health is being supplemented and expanded into a statewide program through this GRMP project.

Every year thousands of lives are saved by cardiopulmonary resuscitation (CPR), external heart massage techniques and other methods of emergency treatment. This program's primary objective is continuing training and re-training of instructors to teach this technique to others who have need of CPR proficiency, such as hospital personnel, ambulance drivers, policemen, firemen, rescue workers, safety instructors, etc. Through workshops conducted throughout the State and in-service training programs in hospitals, participants are being taught advanced methods of emergency treatment by trained CPR instructors. Coordinating the project is Miss Frances Long of the Georgia Heart Association staff. Dr. Joseph Wilbur, Director of the Cardiovascular Disease Control Service at the Health Department, is Medical Director.



(Top) Dr. Robert Franch, Director of the Cardiovascular Diagnostic Service at Emory, is shown with equipment used in the GRMP-sponsored Project for Coordination of Facilities. (Lower) Miss Jacquelyn Hill, CPR representative for the Georgia Heart Association, and Dr. Ronald Masden, U.S.P.H.S., who assists in several projects of the State Health Department's Cardiovascular Disease Control Service, are shown demonstrating CardioPulmonary Resuscitation technique to members of the Atlanta Ski Patrol.

GRMP / Continued

As a first step, a committee was formed composed of representatives of health professions, industry and public service organizations with an interest in the program. Questionnaires were developed to determine the status of proficiency in the techniques of CPR throughout the State and distributed to hospitals of over 100-bed capacity. Training sessions were conducted for representatives of GHA, GRMP, and the Health Department, and in November, the first CPR Faculty Training Workshop was held at the Communicable Disease Center and at the Emory School of Medicine in Atlanta. Dr. Archer S. Gordon, nationally prominent CPR Consultant, served as guest instructor.

Faculty Instructors

Letters of invitation were sent to the Local Advisory Group Chairmen of the 41 qualifying hospitals, requesting recommendation of a physician to serve as a faculty instructor to participate in the CPR training. He would then accept the responsibility for developing an in-service training program at his own hospital and later for offering CPR training to hospital personnel in surrounding counties. Out of the 41 hospitals, 37 agreed to participate as recommended. The CPR Faculty Training Session was attended by 36 physicians and 18 nurses.

Since November, CPR Representatives and GRMP Field Staff have visited 34 of the participating hospitals. Four in-hospital training sessions have been conducted and seven out-of-hospital workshops held for such organizations as the Georgia Ski Patrol, The Physical Therapists of Georgia, the DeKalb County Fire Department, and the Metro Ambulance Service. During January, February and March, a total of 17 training sessions have been scheduled throughout the State for both in-service hospital personnel and others from surrounding counties.

Coronary Care Program in Small Hospitals (A Feasibility Study)

The one-year feasibility study for development of a coronary intensive care program in small hospitals is currently being implemented. This study employs the use of monitoring units in small hospitals directly connected to an operative coronary intensive care unit in a medical center where transmission will be monitored by trained personnel. The equipment for transmitting electrocardiograms is purchased by the community hospital. Open telephone lines enable direct consultation between doctors at both hospitals.

The four participating community hospitals and three medical centers are being linked together in the following manner: Tanner Memorial Hospital,

Carrollton, linked to Grady Memorial Hospital, Atlanta; R. T. Jones Memorial Hospital, Canton, linked to Georgia Baptist Hospital, Atlanta; Hart County Hospital, Hartwell, linked to Medical College of Georgia, Augusta; and Evans Memorial Hospital, Claxton, linked to Medical College of Georgia, Augusta. Dr. J. Willis Hurst is directing the project at Grady, Dr. C. Dan Cabaniss at Georgia Baptist, and Dr. A. Calhoun Witham at the Medical College.

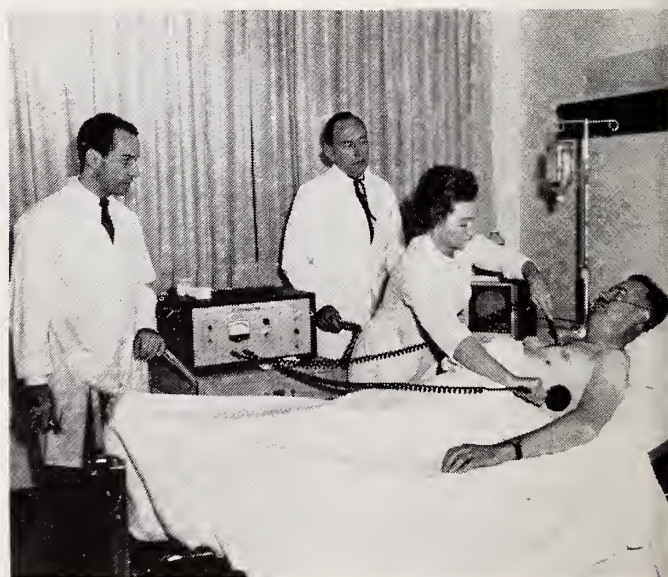
Evaluation plans and techniques for these units have been defined, and the needed information will be secured by using a voice write-out connected to the dataphone located at the medical center.

Site visits at each of the hospitals have been made, and the establishment of minimum necessary training for coronary care personnel in the small hospitals is under way.

First Unit in Operation

The first hospital to have both its monitoring equipment and Data Phone lines installed was Evans County Hospital at Claxton. Dr. Curtis Hames, Project Director for Claxton, has been most enthusiastic about the program from the beginning. He has arranged with Dr. Walter Lewis, Project Director, Medical College of Georgia, for a daily consultation, with Claxton having primary responsibility for the patient, since they will have a complete picture of the clinical problem.

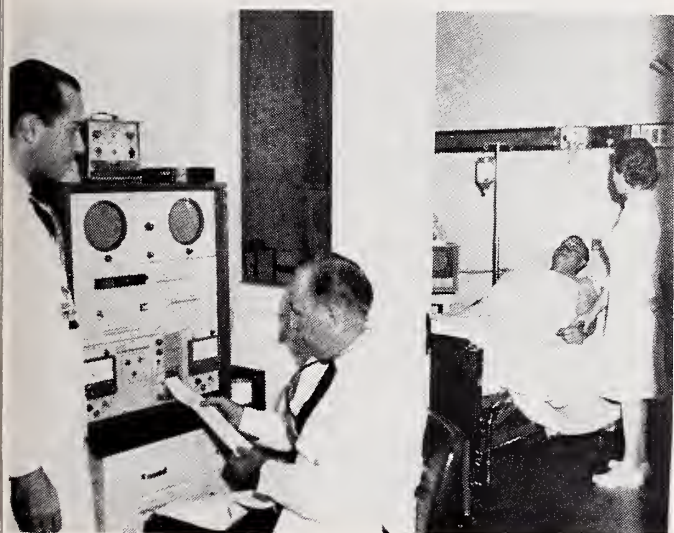
The nurses at Claxton have received extensive training. All have attended the Coronary Care Training Program at Georgia Baptist Hospital sponsored by U.S.P.H.S., and their two-bed coronary care unit has been in operation for several months prior to their linkage with the Medical College.



Dr. Allen Bartell (left) of the U.S.P.H.S. Heart Disease Control Program, and Dr. Curtis Hames, Chairman of the GRMP Local Advisory Group at Evans Memorial Hospital, Claxton, watch as a nurse demonstrates how the new mobile equipment will be used with a cardiac patient when the monitoring hookup is completed with the Medical College at Augusta.

Dr. Allen Bartell is assigned to the Evans County Health Department by the Heart Disease Control Program of the U.S.P.H.S. He has been intimately involved in the development of the unit at Evans County Hospital and has assisted in recruiting and teaching personnel to man the unit.

Dr. Bartell says: "In an effort to aid the population of Evans County with the large number of cardiac patients stricken with coronary artery disease



Set-up of new Coronary Care Unit at Claxton. Monitoring equipment and dataphone will link the unit to the Medical College of Georgia in Augusta.

and myocardial infarction, we have established the two-bed coronary care unit in the Evans Memorial Hospital, which is a 42-bed hospital. The unit is manned by technicians who were trained both here and at Georgia Baptist Hospital in Atlanta with the help of the Regional Medical Program and the Heart Disease Control Program. The patients are monitored continuously, given intravenous medications, and cared for just as in larger hospitals, with the exception of the telephone hookup with the Augusta Medical College, which hopefully will bring the consulting cardiologist to the bedside in a rural community. This is an unusual situation in that a patient stricken in Evans County can be saved the first few hours in which the mortality rate of myocardial infarction is the highest. He can receive immediate medical attention through the cooperative efforts of the monitoring medical center and the patient's local physician while being cared for in the local hospital.

"Thus far we have had approximately 25 patients who have been monitored through the coronary care unit. We have been impressed with the success that we have had in terms of treatment of arrhythmias and general care of myocardial infarction patients."

Developing Personnel

Dr. Hames commented: "Aside from the overall development of the program, I have been also inter-

ested in the mechanics of developing personnel, the economic factors involved and how a prototype for the small rural hospital can be worked out here in Evans County, so that it can be applied to other hospitals of fewer than 100 beds.

"In an effort to surmount the personnel problem with the help of Dr. Bartell, all the technicians who have been manning the monitors have been recruited locally. All of them have medical interests but are



Dr. Alan Bartell, U.S.P.H.S., instructs Coronary Care Unit Staff at Evans Memorial Hospital in Claxton.

not necessarily medically trained personnel. We feel that there is a large reservoir of competent personnel who can be recruited locally if such a program is instituted and carried out."

The training program for the other hospitals is proceeding on target with nurses from Carrollton and Canton having received training at the Dog Laboratory, Emory School of Medicine, in the principles of defibrillation. Arrangements are presently being made to have conferences between nursing staffs and medical staffs of the hospitals involved prior to the opening of the units. Part of these conferences will be devoted to establishing policies for each unit.

Statewide Cancer Program

It is estimated that there are over 13,000 new cancer patients each year in Georgia, resulting in over 5,000 deaths and a minimum economic loss to citizens of over \$26.5 million.

The purposes of this program are to: (1) foster a program of prevention through education of the general public and health professions; (2) promote early detection methods to the public and the professions; (3) provide early and effective therapy at facilities within easy reach of patients; and (4) establish accurate follow-up of cancer patients.

This is being accomplished through establishing Area Cancer Facilities, supporting cancer programs in hospitals, providing continuing education pro-

GRMP / Continued

grams for medical and allied personnel, establishing a Statewide tumor registry, and aiding in recruitment and training of personnel.

A one-day workshop was held in December in Atlanta for Directors of Area Cancer Facilities and Secretaries of Tumor Registries in Georgia.

Seven Area Facilities are already in operation at the following hospitals: The Atlanta Medical Center, Crawford W. Long Hospital, and St. Joseph's Infirmary, Atlanta; Memorial Medical Center, Savannah; The Medical Center, Columbus; City-County Hospital, LaGrange; and Phoebe Putney Memorial Hospital, Albany. A total of 12 Area Facilities will be established.

Through organized efforts of the Area Cancer Facility Directors, teaching consultation sessions are being planned in conjunction with individual, scheduled hospital staff meetings.

Consultants discuss with members of the Area Cancer Facility the diagnostic and therapeutic problems of the patients, and encourage a self-audit of the clinic through study of recent, past and present patients with cancer of specific sites.

The local Tumor Registry provides data for local self-analysis of incidence, staging and results of treatment.

Teaching consultants are largely supplied by cancer institutes, hospitals, and the schools of medicine.

Cancer Workshops

Through special scheduled workshops, physicians, already knowledgeable in cancer, will have the opportunity to keep themselves abreast of the very latest discoveries in their field. Workshops will be sponsored by the Georgia Regional Medical Program, the Georgia Division of the American Cancer Society, the Cancer Committee of the Medical Association of Georgia and by both medical schools, and will be scheduled for one or two-day sessions.



Dr. Warren Cole, Project Director of the Committee on Guidelines on Cancer Care of the American College of Surgeons' Commission on Cancer, is a Special Visiting Consultant to the Tumor Board Conference at Georgia Baptist Hospital. The Atlanta hospital recently was designated an Area Cancer Facility of GRMP.

Subjects covered by the workshops will be those problems encountered in the diagnosis and treatment of the cancer patient such as: (1) hematologic malignancies, (2) chemotherapy of solid tumors, (3) cancer registries—use of registry data—feed-back to local cancer facilities, (4) radiation therapy—new concepts—isotopes, calculation isodose curves, (5) cancer detection, (6) management of cancer of the head and neck, (7) management of cancer of the breast and soft parts, (8) management of cancer of the GI tract, and (9) management of GYN cancers.

Proposed Tumor Registry

The Statewide Tumor Registry being planned will be a tool to assist physicians in the care of cancer patients and in the follow-up so essential to continuing care by allowing comparative evaluation of cancer therapy and by providing information as to the changing demographic patterns of cancer. Emphasis



Area Cancer Facility Directors meet at GRMP's Atlanta Headquarters with Dr. Robert R. Smith, Associate Director and Director of the Cancer Program.

will be given to biostatistical support and to training in biometry.

There are at present 18 registries located in hospitals throughout the State. These will be expanded to other hospitals in the area, so that all counties of the Georgia region will eventually be covered.

National Cancer Survey

The National Cancer Institute is planning a 3-year cancer survey to be done in ten cities and two States across the country during the period 1969-71. The areas (Atlanta, Birmingham, Dallas, Ft. Worth, Denver, Detroit, Minneapolis-St. Paul, New Orleans, Philadelphia, Pittsburgh, San Francisco, and the States of Utah and Iowa) were chosen according to several criteria. These included the variation in geographic area, racial and ethnic composition, medical facilities available, and whether the area was included in the two previous national cancer surveys done in 1937 and 1947-48. In each area the National Cancer Institute will support all phases of the data collection by means of a contract with a non-profit, medically-oriented organization to hire field staff and gather data. The Georgia Regional Medical Program has been contracted for the five-county Atlanta survey.

Complete coverage of population groups included in the new survey will provide physicians and public health officers with reliable answers to important questions. Incidence and prevalence rates will be established for various forms of cancer according to age, race, sex and other variables. Medical information sought will include the primary site and histologic types of tumor, dates, locations and methods of diagnosis and treatment. Information available from any existing cancer registry or continuing survey in a study area will be utilized to avoid duplication.

Detailed Studies

A 10 per cent sample of patients will be studied in detail to ascertain economic effect of cancer on the patient, his family and the community, the use of medical facilities as well as the general course of the disease. For the 10 per cent sample, a more detailed review of hospital records will be requested, an interview with the attending physician and an interview with the patient or a family member. In *no case* will an interview with a patient or his family be attempted unless the physician has given permission. Particular attention will be given to maintaining the confidentiality of all records and to obtaining free and informed consent to any interview.

Basic calculations and progress reports will be prepared during the course of the survey. The main report will be a detailed analysis of cancer incidence rates on a national level. Several *ad hoc* reports

covering subjects of special interest will be prepared, such as the relation between occupation and cancer incidence and the burden of cancer on the national economy. Summary reports on each of the study areas will be prepared for the use of local physicians, hospitals, public health workers and other interested persons. Director of the cancer survey and the statewide tumor registry is Dr. James P. Cooney of the GRMP staff.

Pediatric Chronic Pulmonary Disease Center

This GRMP project was developed in conjunction with the Respiratory Center Program of the Medical College's Department of Pediatrics in Augusta. It entails a comprehensive regional care, teaching and research program for children with chronic and potentially disabling respiratory diseases.

Dr. Frank Anderson, Director of the Center and Coordinator for the project, reports some 200 patient visits per month. The objective of the program is to expand both in-patient and out-patient diagnostic and special treatment services for children throughout Georgia and the neighboring portion of South Carolina. In addition, training opportunities for physicians, nurses and allied health personnel are being enlarged.

Comprehensive out-of-hospital evaluation and follow-up is being provided with hospitalization recommended for children requiring extensive or complex diagnostic or treatment measures, extended training techniques, or special observation or study. Findings and recommendations are reported to referral physicians.



Dr. Frank Anderson demonstrates the use of a deep breathing respirator at the Medical College of Georgia Respiratory Center.

GRMP / Continued

Research and regular review of cumulative data is being conducted, along with clinical inquiry into the alterations in physiologic function in children with chronic respiratory disease and the means by which observed changes can be modified or prevented.

An innovative voice-to-voice communications system is being developed as a practical method of enhancing and maintaining communication between the medical center and the local community for physicians, nurses, social workers, etc.

At a recent two-day seminar in Augusta on the problems and needs of patients with emphysema and chronic bronchitis, Dr. Anderson urged that a study be made of families in whom children have "more than their share" of respiratory infections, noting that a number of families have allergic respiratory systems. The meeting, sponsored by the Georgia Department of Public Health and GRMP, was attended by nursing consultants, physical therapy consultants and Chronic Disease Program representatives.

Medical Specialty Assistant Program

The Medical Specialty Assistant Program is designed to train experts in the practical and technical aspects of patient care in the Medical Coronary Intensive Care Units. The two-year program, jointly sponsored by Emory and GRMP, is under the direction of Dr. Alan Paulk. Assisting Dr. Paulk is Miss Ann Flewelling, R.N., Coordinator of the Medical Intensive Care Unit at Grady Hospital where the courses are being conducted.

In a recent progress report, Dr. Paulk had this to say concerning the project: "In 1965, Dr. Eugene Stead proposed the idea of the Physician Assistant Program designed to help fulfill some of the medical needs for the population. For the past two and one-

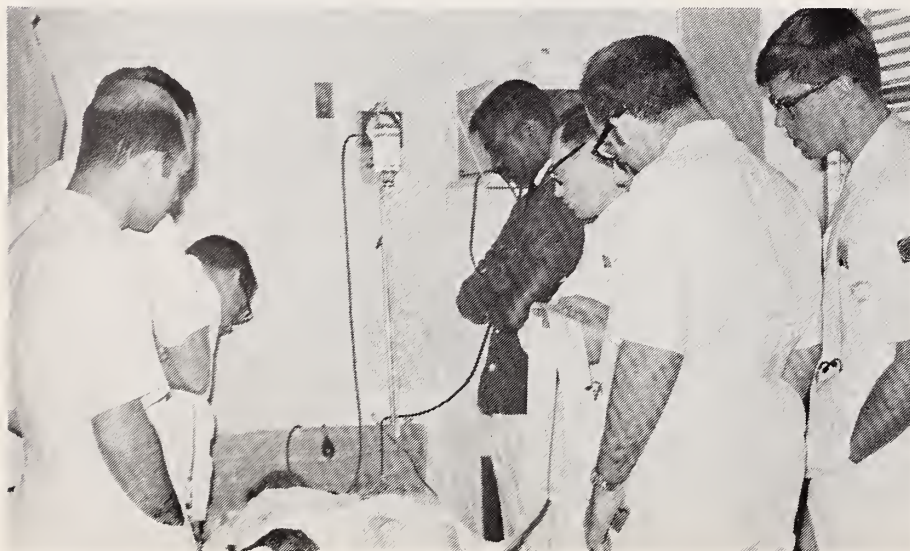


Thomas Walker and Bob Smith, Medical Specialty Assistants in training at Grady Memorial Hospital observe patient in the Medical Intensive Care Unit.

half years, a program has been established at Grady Memorial Hospital in which individuals are trained in the specialized areas of intensive medical care and coronary care. These individuals are known as Medical Specialty Assistants.

Trained for Any Emergency

"In this program we have tried to direct our efforts at recruitment to individuals having several years' training as hospital corpsmen in the Armed Forces, feeling that these individuals have the sufficient background to be able to move into a two-year training program which is intensive, but highly specialized, to become competent technicians to handle many emergency situations which might arise in a Coronary Care Unit or Medical Intensive Care Unit in any hospital. These individuals are given intensive



Thomas Walker, Medical Specialty Assistant (fifth from right), is shown on ward rounds with the Grady Hospital House Staff in the Medical Intensive Care Unit.

background in physiology, pathophysiology and pharmacology. They are trained to be able to handle any cardio-respiratory emergency: being able to establish airways in the unconscious patient, to do external cardiac compression or cardiac resuscitation, to handle with ease all of the problems of an electrical monitoring device, including defibrillation to a patient with cardiac arrest. In order to gain this efficiency, these individuals must have intensive training in understanding electrical physics and cardiac arrhythmias from the electrocardiogram.

"This program has grown so that under the auspices of the GRMP we are allowed to take six new students yearly for a two-year program. Our numbers of applicants have increased sharply, and we feel that the program has established itself and that the calibre of the individuals being produced in this program will be competent to handle the problems of medical intensive care and coronary care in any hospital in the region.



Mrs. Lucille Dismukes, RN, the GRMP Nursing Coordinator, consults with the Nursing Committee on the role of nursing in operational projects.

"There have been four graduates of this program. We have three students in their second year of training at the present time. And on the 14th of January, 1969, a new class started with four additional students."

Courses are taught by faculty members of the Emory School of Medicine, Fellows, Grady Memorial Hospital house staff and other qualified personnel. They consist of classroom lectures, laboratory experience and clinical experience. No tuition is required and a monthly stipend is paid to students for satisfactory performance.

Atlanta Metropolitan Area Home Health Services

The mission of the project under the auspices of the Hospital and Health Planning Department, Community Council of the Atlanta Area, Inc., is to "devise a Home Health Services system for the five Metropolitan counties and ten contiguous counties."

Initial interest stemmed from the shortage of general hospital beds, particularly in the downtown area.

Through this program, emphasis is being placed on early discharge from hospitals of patients for whom professional health care services in the home can be provided. Two hospitals in Atlanta, St. Joseph's Infirmary and Crawford W. Long, now have full-time Nurse Coordinators whose responsibilities include assistance with patient-teaching and other activities to promote continuity of care to patients, whether they are going to their own private homes or to extended care facilities, nursing homes or foster homes.

The primary goal of this project is to develop a system which will continue to function after the grant terminates—a system which will serve all patients needing services. Effective working relationships are being developed with hospitals, nursing homes and other institutions in order to achieve continued care without delay and with physicians to

utilize such services. As a result, selected patients are receiving better coordinated health services. An increasing number of health professionals, other citizens, agencies and institutions are committed to the concept of continuity in Health Care Services, and view Home Health Services as a vital component of patient care.

Progress to date also reveals a recommendation from the present Advisory Group that a central coordinating agency be established. Such an agency will provide a more effective framework for increased communication and cooperation. It will perform *per se* functions to speed up changes in the present delivery of Home Health Services.

(Further reports on the progress of these projects will appear in subsequent issues of the *Journal*. Meanwhile, additional project proposals are being considered by GRMP Task Forces for development within the regional concept.)



MAG IN AMA

THE MEDICAL ASSOCIATION OF GEORGIA is endowed with an outstanding delegate representation to the American Medical Association. Our delegation is highly respected in the American Medical Association by all AMA delegates, and they are noted for their hard work and diligent attention to the deliberations and actions of the House of Delegates.

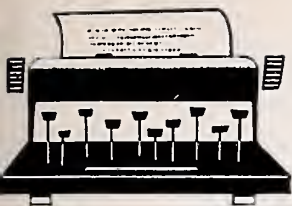
Among this delegation, we are fortunate to have one such as Dr. J. Frank Walker, a brilliant and dynamic young physician who has already demonstrated his leadership and ability in various activities. All of you are certainly aware of his outstanding performance as Speaker of the House of Delegates of the Medical Association of Georgia from 1961-1968. As chairman of the Legislative Committee of the Medical Association of Georgia for the last several years, he has proven to be most knowledgeable with regard to legislation both national and within our State, and he is well versed in parliamentary procedures. Among many honors and achievements he has served on several important American Medical Association Committees, including membership in the AMA Council on Legislative Activities for the past eight years.

The Medical Association of Georgia is sponsoring his candidacy for Vice Speaker of the House of Delegates of the American Medical Association. His name will be placed in nomination at the annual session in July. He stands an excellent chance of being elected, which will further enhance the stature of Georgia in the American Medical Association. Undoubtedly, there will be several candidates running and it is most important that we actively support our man *now*. It would be most helpful if each of you would write or phone or wire your good friends in the other States and urge them to speak to their State American Medical Association delegates in favor of Frank Walker.

We have the best man and we sincerely want him to win.

Charles R. Andrews Jr. M.D.

Charles R. Andrews, Jr.
President, Medical Association of Georgia



Conference of Conferences

FEW MEETINGS DURING THE YEAR will attract a higher calibre of participant than will the biennial Conference on Medical Education which will be held at Callaway Gardens beginning February 28.

Selected physicians involved in the education of medical and allied health personnel have been invited to participate in the three-day meeting to discuss objectively and to offer suggestions on improving these educational programs in Georgia.

Topics for Discussion

We believe that the topics chosen for discussion have much merit. The proper "Training and Utilization of Allied Health Personnel" is a must in our ever demanding and complex society. Medical educators must take the lead in directing a curriculum which will qualify the student to perform his duties efficiently and conscientiously upon graduation.

Continuing Education

Closely related is the problem of "Continuing Medical and Allied Health Education." A physician does not have to be told that continuing one's education in some manner after graduation from medical school is necessary. In fact, at least one state medical society has voted to make continuing medical education mandatory and a requirement for continued membership in the society. Many other states are looking at the possibility of doing this very same thing.

FLEX Examination

There has been much interest over the nation about the FLEX examination, which in many cases will replace state medical board examinations. The FLEX examination is an attempt to standardize examinations and make the system of reciprocity less cumbersome. This will be on the agenda for the Conference and may influence a possible decision to offer the FLEX in Georgia in the future.

It is gratifying to note that so many of Georgia's medical educators are taking an active role in the Conference. We feel that this group of physicians holds the future of medical care in their hands.

The Threat of Chiropractic

AT THE LAST MEETING of the AMA House of Delegates held in San Francisco, a resolution was passed calling on State and county medical societies to alert the general public to the health hazards posed by the cult of chiropractic.

Text of Resolution

The resolution, passed by the House of Delegates, reads:

"Whereas, the American Medical Association House of Delegates adopted a Statement of Policy on Chiropractic which states, in part, that 'Chiropractic constitutes a hazard to rational health care in the United States because of the substandard and unscientific education of its practitioners and their rigid adherence to an irrational, unscientific approach to disease causation,' and also that 'The delay of proper medical care caused by chiropractors and their opposition to many scientific advances in modern medicine, such as life saving vaccines, often end with tragic results'; and

Whereas, Physicians have direct and personal responsibility to provide the best scientific medical care, and protection of the public health always has been a primary mission of the members of the American Medical Association; now therefore be it,

Resolved, That the American Medical Association urge its constituent state medical associations, and all component medical societies to formally adopt the AMA Policy Statement on Chiropractic, or a somewhat similar expression; and be it further,

Resolved, That the AMA urge state and county medical societies to alert the general public to the health hazard posed by the cult of chiropractic."

Chiropractic poses a continuing problem in the health field and it is the obligation of physicians everywhere to do all within their power to educate their patients concerning this obvious cult that preys upon the unsuspecting for a practice.

MAG Committee Supports Resolution

MAG's Committee on Public Service has reviewed this resolution and recommends that this problem be brought to the attention of county medical societies and that this resolution be implemented locally.

Never let it be said that Georgia medicine did not do its part in the eradication of these discreditable practitioners.

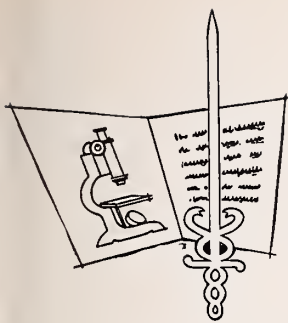
AMA Urges That Physicians Voluntarily Adopt Minimum Wage

RECENTLY AT AN AMA ANNUAL CONVENTION, a report was adopted calling on physicians around the country to adopt voluntarily the minimum wage for all employees. The U.S. Department of Labor has determined that physicians are engaged in interstate commerce and come under the Fair Labor Standards Act, which establishes minimum wage.

Notwithstanding the fact that the AMA vigorously opposed the U.S. Department of Labor's interpretation of the Act, the opinion of the Labor Department prevails.

The Legal Research Department of the AMA has made a thorough study of the question and believes that certain physicians do not come under the provisions of the Fair Labor Standards Act. Should a Federal representative call, it would be wise to retain legal counsel should there be any reason to believe that you do not come under the Act.

In such case, it is requested that you keep MAG informed.



ROUTINE PAP SMEAR ON ALL FEMALE PATIENTS ADMITTED TO HOSPITALS

ONE OF THE GREATEST ADVANCES in cancer control has been the use of the Pap smear, especially for the detection of early cancer of the cervix. Nonetheless, more than 10,000 females die each year from cancer of the cervix. In reality, if every woman had the Pap smear regularly and routinely, it is conceivable that death from cancer of the cervix could be eliminated.

MAG Cancer Committee Recommendation

The Committee on Cancer of the Medical Association has deliberated at length as to how every woman should have a Pap smear. The committee has proposed that all hospitals adopt a policy that a Pap smear be done on all female married patients and on all unmarried female patients above the age of 20 entering the hospital, if the patient has not had one within the past year. This would include a large number of patients entering the hospital for other medical problems who had never had a Pap smear or one within a year.

Dr. Sidney J. Cutler has released a report on the experience of 100 U. S. hospitals in cancer therapy from 1940 to 1964. He reports that about two-thirds of all cervical neoplasms are now discovered in the in situ stage. The remaining one-third of patients are discovered with invasive cancer. It is this group of patients that we should become more concerned about in making use of the Pap smear for everyone.

It is hoped that the staffs of the hospitals will view this in the light of preventive and progressive medicine.

*Hoke Wammock, M.D., Chairman
MAG Committee on Cancer*



AVOIDING PITFALLS IN IMPLEMENTING A LOW SODIUM DIET

GLEN E. GARRISON, M.D., *Augusta*

THE IMPORTANCE OF RESTRICTION of dietary sodium in chronic congestive heart failure, hypertension, certain types of renal disease, and other conditions has been firmly established.

At the practical level it must be appreciated that telling chronically ill adults to make large changes in their long-established dietary habits is an order which is difficult for them to follow. When such a medical recommendation is made, increased attention should be given to improving health education of the patient and responsible members of his family in an attempt to implement the therapeutic diet more consistently. The person in the household responsible for the cooking should be included in the dietary instruction for obvious, but often overlooked, reasons.

Helpful Pamphlet for Patients

If the clinical indication for low sodium diet is congestive heart failure, physicians will find it helpful and efficient to give some patients a pamphlet entitled "Congestive Heart Failure—A Guide for the Patient," copies of which may be obtained from the Superintendent of Documents, U. S. Government Printing Office, Washington, D. C. 20402, for ten cents per copy or \$5 per 100 copies ("Public Health Publication No. 1056 in Health Information Series No. 108"). This pamphlet is well written and will be helpful to patients and families having average or superior educational attainment, but will not be particularly beneficial to patients in the lower educational levels where the majority of chronic congestive heart failure has been demonstrated to occur.

Sodium in Water Is Overlooked

The sodium content of most common foods has been determined, and this information is widely available and utilized in prescribing sodium restricted diets. On the other hand, it is unfortunate that inadequate attention has generally been given to the sodium concentration of water that is ingested. The clinical condition of many patients on sodium restricted diets has undoubtedly been impaired by the ingestion of unrecognized large amounts of sodium in water. Severe exacerbations of chronic congestive heart failure due to sodium in water have been documented.

The widely used American Heart Association's 500 mg and 1,000 mg sodium-per-day diets are based on the use of water that contains no more than 20 mg of sodium per liter. The sodium content of the food in this 500 mg sodium diet is approximately 440 mg, leaving a maximum of 60 mg for the sodium content of water. Consequently, a patient can follow this 500 mg sodium diet and consume water hav-

ing sodium concentration up to 200 mg per liter and usually keep his sodium intake down to approximately 1,000 mg per day. However, if the patient's condition requires that sodium be limited to 500 mg per day, the water used must not contain over 20 mg of sodium per liter. Distilled water can be purchased if suitable natural water cannot be obtained.

Analyze Municipal Water Supplies

Between 1963 and 1966 the Public Health Service measured the sodium concentration of water in approximately 2,100 municipalities throughout the United States. The concentration of these water supplies varied from 0.4 to 1,900 mg per liter. The water from approximately 42 per cent of the towns had a sodium concentration greater than 20 mg per liter, and the sodium concentration was greater than 250 mg per liter in approximately 5 per cent of the towns. Physicians and/or the county medical societies should ask water plants in their areas to tell them the sodium concentration of the municipal water supplies. If this information has not been determined, the local and/or State health department can be asked to assist in having the appropriate analyses performed.

Varied Concentration in Private Wells

Several small surveys have been done on water from private wells. The water from approximately one-half of a group of private wells in Durham County, North Carolina, was found to have over 25 mg of sodium per liter, and the highest six per cent were between 100 and 150 mg per liter. A survey in Alberta, Canada, revealed that about one-half of the private wells had a sodium concentration over 100 mg per liter. Sodium concentration in excess of 4,000 mg per liter has been documented in well water that did not even taste "salty." Private wells within a local community frequently have markedly different concentrations of sodium.

Water Softeners Add Sodium

Many natural water supplies (particularly from wells) are excessively "hard." "Hard" water interferes with the desirable actions of soap and is harmful to the plumbing system, especially hot water heaters. Artificial water softeners are understandably being used with increasing frequency by cities and in particular at homes having wells with "hard" water. These water softeners are designed to remove the "hard" cations (calcium and magnesium), and all commercially available ones add sodium to the water in exchange for the "hard" cations. Therefore, the "harder" the natural water the higher the subsequent sodium concentration of the water after it has been softened.

In Durham County (North Carolina) the water from 80 per cent of homes with private wells and home water softeners was found to contain over 100 mg of sodium per liter, and the highest concentration was 1,000 mg per liter. Water that is sufficiently "hard" to make softening desirable will be unsuitable for a low sodium diet after it has been "softened."

Proper education of the patient and other responsible family members and the elimination of unrecognized sources of sodium are essential in the successful implementation of a low sodium diet.

—Medical College of Georgia

ITEMS OF INTEREST FROM THE HOSPITAL ACTIVITIES COMMITTEE

AT THE JUNE 1968 AMA CONVENTION, several resolutions were presented and passed by the House of Delegates concerning the hiring of ancillary personnel by hospitals. In some hospitals, these employees are encouraged and permitted to carry out their treatment of patients without physician's orders and without proper medical supervision. All members of the Medical Association of Georgia should be alert and aware of this trend so that they can be sure that any ancillary personnel hired by hospitals will be supervised by the medical staff and treat patients only on the orders of the physician.

Multi-phasic Laboratory Testing

The House of Delegates of AMA also considered a number of reports and resolutions concerning multi-phasic laboratory screening tests. The development of procedures, techniques and equipment have made these multi-phasic tests available at a reasonable cost to the patient. As a tool for the early detection of unsuspected diseases, multi-phasic testing has become popular and routine in many physicians' practices. As the demand increased for this service, more laboratories were established and many of these laboratories performed only multi-phasic tests.

In recent months, there have been many authorities questioning the reliability of the tests and some laboratories, especially when the laboratory performing the tests is located at a distance from where the blood was drawn. Physicians are advised to select carefully the laboratory and be sure of the reliability of the results reported. Under no circumstances should the multi-phasic tests be used as being sufficient to make a diagnosis and when a specific test is abnormal, the physician should use clinical judgment and further specific studies to verify the abnormal findings.

Encouraging Hospital Accreditation

The joint Commission on Accreditation of Hospitals has extended accreditation to hospitals of six or more beds. Until the Hospital Activities Committee can establish a sub-committee on accreditation, every physician in the State is asked to actively seek to obtain accreditation for every hospital not already accredited. In the future, teams consisting of a physician and hospital administrator will seek to encourage accreditation through education and assist any hospital which desires to seek accreditation. These same teams will be available for mediation of hospital-staff disputes when requested by both parties.

Less Paper Work for Physicians

This committee has been studying means to lessen the paper work load on physicians and seeks to recommend the standardization of hospital records. Clarifica-

tion is being sought about policies of the JCAH regarding the use of automated equipment for charting. The possible use of computers in hospitals is being given intensive study and is being carried out with a committee from the Georgia Hospital Association.

Physician Appointments to Hospital Boards

The House of Delegates of MAG passed a resolution seeking the appointment of a physician on every hospital board or authority and in order to accomplish this, they called for legislation to be presented to the Georgia General Assembly. After much thought and deliberation, it was felt that no legislation should be presented at this time to require that a physician be appointed on hospital boards or authorities. At the present time, there has been an increase in the number of physicians being appointed voluntarily by appointing authorities. Since there is no provision in the present law which specifies who should be appointed, and since the appointment of a physician is not prohibited, voluntary appointments of physicians are being sought. Every staff should approach the appointing agency and seek such appointments through local political means.

Permanent Staff Appointments

A resolution calling for permanent staff appointments was also passed by the House of Delegates. In order to provide for discipline of staff members without the use of yearly appointments for disciplinary reasons, the Hospital Activities Committee is in the process of writing an outline of provisions for discipline which should be incorporated in the Constitution and By-Laws of each staff. If disciplinary provisions are provided and enforced, most hospitals will be willing to make Senior Staff appointments on a permanent basis. The JCAH recommends yearly renewable appointments and their opinion is being sought regarding their acceptance of permanent appointments in considering hospital accreditation.

MAG and GHA Cooperation

Most disputes between hospitals and medical staffs have arisen out of the lack of understanding of the role of each member of the health care team in the provision of medical care for the patient. The Hospital Activities Committee is preparing a statement which will be jointly issued by the MAG and GHA at a later date.

Representatives from the Georgia Hospital Association have met with our committee and are working closely with us. We have found that they agree with the physicians and are working toward the same goals. Our committees will work closely with their committees so that more can be accomplished and full cooperation be realized by joint endeavor.

Alex P. Jones
Chairman, Hospital Activities Committee

HIGHLIGHTS OF THE COUNCIL MEETING

DECEMBER 14 AND 15, 1968

This summary covers only major actions and is not intended as a detailed report in lieu of meeting minutes.

Finance Committee Report—1969 Budget as presented by the Committee on Finance was approved. Also voted to recommend a \$30 assessment to the 1969 House of Delegates and asked that the Special Finance Committee discuss this and other methods of meeting increased costs of operation.

Liaison Committee With Board of Medical Examiners—Approved the establishment of a joint Board of Medical Examiners to license M.D.'s and D.O.'s. Attorneys were authorized to proceed with the drafting of a bill for approval by Executive Committee and Legislative Committee.

Constitution and Bylaws Committee Report—Changes in the Constitution and Bylaws to be recommended to the 1969 House of Delegates were approved in principle.

Cancer Committee Recommendations—Adopted a resolution from the Cancer Committee endorsing campaigns to publicize the health hazards of smoking. In addition, approved for distribution a statement calling on hospitals to institute a policy toward having a greater number of female patients to have a PAP Smear.

Awards Committee Report—Accepted recommendations of Chairman John S. Atwater, M.D., which will improve methods of selection of recipients of MAG Awards.

Ad Hoc Committee on Elections—Approved for reference to the 1969 House of Delegates recommendations by Chairman J. W. Chambers, M.D., that MAG officers be elected by the House of Delegates.

Legislative Report—Voted to sponsor a bill which would allow treatment of V.D. in minors without con-

sent of parents or guardian, and approved the introduction of the Uniform Anatomical Gift Act.

State Board of Health Report—On hearing from Board Chairman, Beverly W. Forester, M.D., voted approval of the principles in the mental health Bill of Rights, endorsed legislation on fluoridation of water supplies in cities with over 5,000 population, and referred to the Hospital Activities Committee the matter of some procedures being beyond the fee-for-service concept.

GaMPAC—Confirmed appointments to the GaMPAC Board of Directors.

MAG Foundation—Reappointed J. Frank Walker, M.D., to the Board of Trustees and appropriated funds for an all-member mailing.

Headquarters Office—Resignation of MAG Field Representative, William V. Wallace, was announced, effective early in 1969.

Field Service Report—Voted to assign responsibility to the Councilors for pending County Society mergers. Involved are Rabun (9), Lamar (6), Tri-County (1), and Jasper (10).

Council Also Took the Following Actions: Voted to commend Fleming L. Jolley, M.D., for his outstanding work in Traffic Safety and Earnest B. Atkins, M.D., for outstanding leadership of GaMPAC's accomplishments.

—noted with regret the deaths of David R. Thomas, M.D., Augusta, and Eustice A. Allen, M.D., Atlanta

—referred to the Insurance and Economics Committee the matter of seeking simplified Workmen's Compensation claim forms

—approved the acceptance by F. William Dowda, M.D., of a committee chairmanship with the American Society of Internal Medicine.

TWO-WAY RADIO SYSTEM PROVES A SUCCESS

In the event of a disaster, whether it be a traffic accident, tornado, flood, or one of any number that could strike, two-way communications is a must. And, it goes without saying that the community that has already taken time to set up such a system is ahead of the game should tragedy come.

Physicians, hospitals, and funeral directors in the Vienna-Cordele area have been operating a two-way radio communications system for about ten years, and it has proved most successful.

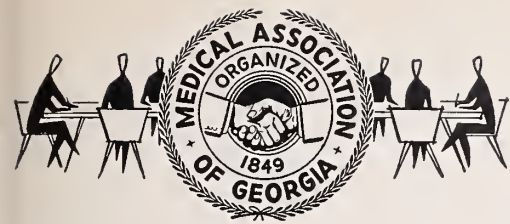
Each of the groups installed a radio that kept them in constant contact with each other. The system in the area has been most helpful, although at times the frequency becomes heavy with traffic from other interests. Nevertheless, the communications system has been working well for a decade and there are no plans under way to discontinue its use.

Communities that do not have such arrangements should take a long, hard look at the advantages. Some kind of communications system in rural Georgia seems

indicated. The physicians in these south Georgia communities believe that it is the two-way radio system.



Base station at Dooley Hospital in Vienna is operated by the nurse on duty.



THE ASSOCIATION

NEW MEMBERS

Sadler, Glendy G., M.D. Active—Laurens—Path	VA Center Dublin, Georgia 31021
Smith, Malcolm M., M.D. Active—Laurens—GP	VA Center Dublin, Georgia 31021

SOCIETIES

The second annual Southwest Georgia Medical Seminar was held December 5-6, 1968, in Thomasville. The two-day program is sponsored annually by the **Thomas-Brooks County** and **Dougherty County Medical Societies**.

Guest speaker at the December meeting of the **Cobb County Medical Society** was Arthur Beall, M.D., an associate professor of surgery at Baylor University School of Medicine in Houston, and member of the heart research team there.

The **Georgia Medical Society** will co-sponsor a national survey of strokes in the Savannah area. The survey is being conducted by the stroke section of the Heart Disease and Stroke Control Program of the U.S. Public Health Service.

Election of officers for 1969 took place at the December meeting of the **Ogeechee River Medical Society**. Charles Emory Bohler is the new president; W. W. Hillis is vice-president, and Charles R. Richardson is secretary-treasurer.

Louis R. Jelks has been elected president of the **Southeast Georgia Medical Society**, and G. P. Sassos is the new secretary.

Ronald F. Galloway has been installed as president of the **Richmond County Medical Society** for 1969, and Julius T. Johnson has been chosen president-elect of the society. Also installed to serve in 1969 were Menard Ihnen, vice-president; Stephen Mulherin, secretary-treasurer; Joseph L. Mulherin, councilor; and Daniel B. Sullivan, vice chancellor.

Officers of the **Emanuel County Medical Society** are Herbert R. Frost, president; C. Ennis Powell, vice-president; Robert J. Moye, secretary-treasurer and delegate to the Medical Association of Georgia; and H. Wilder Smith, alternate delegate.

Rossville physician Sara Goolsby is the new president of the **Walker-Catoosa-Dade County Medical Society**. Secretary of the society for 1969 is Garland E. Kinard.

The **Georgia Medical Society** has chosen Lawrence Lee, Jr., as president-elect for 1970. Installed as president for 1969 was John G. Zirkle. Other new officers include Darnell Brawner, vice-president; Harry H. McGee, Jr., secretary; and Joseph Doolan, Jr., who was re-elected treasurer. New delegates to the Medical Association of Georgia are William G. Sutlive, with J. Lane Reeves as alternate; and A. F. Williams, with Frank

Johnston as alternate. E. P. Nargeron was named as representative for the endowment fund.

New officers of the **Southwest Georgia Medical Society** include James W. Merritt of Colquitt, president; David Wethersby, vice-president; and Eugene H. Giles, secretary-treasurer. Delegates to the Medical Association of Georgia are James W. Merritt and E. H. Giles; alternates are W. C. Baxley and Turner W. Rentz.

The **Georgia Medical Society** sponsored an all-day symposium on sexual behavior January 14 featuring nationally known experts in the field of clinical psychiatry and obstetrics and gynecology.

Carl Drury has been installed as the new president of the **Camden-Charlton Medical Society**. Other officers for 1969 are Charles Cannon, vice-president and H. H. Robinson, who was re-elected secretary-treasurer.

New officers of the **Bibb County Medical Society** are Joe Sam Robinson, president; Charles R. Ireland, president-elect; S. Charlotte Neuberg, vice-president; Lil James, secretary-treasurer; and Henry Tift, parliamentarian.

PERSONALS

First District

The Sertoma award for Service to Mankind was presented to **Caroline J. Williams** at a recent meeting of the Savannah Sertoma Club. Dr. Williams was cited for her voluntary medical services to indigent patients in the county.

Dearing A. Nash has been elected president of the medical staff at Candler General Hospital in Savannah. Dr. Nash succeeds **William W. Osborne**. Other officers elected at the meeting include vice-president **Franklin P. Bousquet, Jr.**; secretary **Robert H. Carter**; and treasurer **Jeff J. Holloman**. New chiefs of departments are **J. K. Quattlebaum, Jr.**, surgery; **D. H. Willoughby**, medicine; **William G. Sutlive**, obstetrics and gynecology; **David Robinson**, radiology; and **Richard L. Schley, Jr.**, pediatrics.

The new administrator and medical director of the mental retardation clinic of the Chatham County Health Department is **L. Margaret Green**.

Third District

Richland physician **Earl A. Mayo** has been reappointed to a second term as a member of the State Board of Medical Examiners.

The Dedication of Blanchard School, in honor of **Mercer Blanchard** took place recently in Columbus. Dr. Blanchard has served as school physician since 1918.

Seven Columbus physicians have received clinical appointments to the faculty of Emory University School of Medicine to conduct a medical education program for interns, resident and physicians at The Medical Center.

THE ASSOCIATION / Continued

They include **Bernard Hallman** and **McLeod Patterson**, coordinators of the project; **Jack W. Hirsch**, clinical assistant professor of medicine; **Richard M. Shuffstall**, clinical assistant professor of pathology; **Peter C. Graffagnino** and **Hugh J. Bickerstaff**, clinical assistant professors of gynecology and obstetrics; and **William G. Love, Jr.**, clinical assistant professor of surgery. This program is a pilot project under the direction of the Georgia Regional Medical Program.

Fourth District

J. Larry Boss of Villa Rica has been elected vice-chief of staff of the Villa Rica City Hospital for 1969.

Fifth District

Fred Allman was the guest speaker at the November 20 meeting of the Forest Park Rotary Club. Dr. Allman stressed the importance of physical fitness and set forth guidelines for selecting a physical fitness program.

The newly elected chairman of the Northside Hospital medical staff is **Keith A. Quarterman**. Other officers elected at the December meeting include **William E. Huger, Jr.**, vice-chairman; **C. Vernon Sanders**, secretary, and **William M. Pavlosky**, treasurer. Departmental chairmen elected for 1969 include **C. Vernon Sanders**, general medicine; **Frank L. Wilson**, general surgery; **Dan B. Kahle**, obstetrics and gynecology; **Ralph L. Robinson**, pediatrics; **Charles M. Silverstein**, radiology; **George P. Dillard**, psychiatry, and **W. A. Mendenhall**, general practice.

Dean of the School of Medicine at Emory University, **Arthur P. Richardson**, was a guest speaker at the Third Annual Symposium of the National Pharmaceutical Council held in Washington, D.C. Dr. Richardson discussed the subject of education of physicians and the public.

Sixth District

The president of the Middle Georgia Hospital, **Herbert M. Olnick** of Macon, was named Doctor of the Year by the medical staff of the hospital. Dr. Olnick was cited for outstanding leadership in organizing the major expansion programs now in progress at the hospital.

Seventh District

M. V. Dardin of Dalton has recently received certification by the American Board of Obstetrics and Gynecology.

Calhoun physician **R. D. Walter** has been elected vice-president of the Georgia Academy of General Practice.

Kennestone Hospital in Marietta has named **Robert T. Klingbeil** as director of the Physical Medicine and Rehabilitation Department.

DEATHS

Willis E. Ragan

Retired pediatrician Willis E. Ragan of Atlanta died December 17 at the age of 85.

Dr. Ragan was born in Atlanta and received his education at Emory College at Oxford, the University of Georgia, and Columbia Medical School. He was a member of the American Medical Association, the Medical Association of Georgia, Fulton County Medical Society, and the Georgia Chapter, American Academy of Pediatrics.

Survivors include his wife and two brothers, James Ragan of Honolulu and Ralph Ragan of Atlanta.

John Smallbrook Howkins

John Smallbrook Howkins, 75, died December 19 in Savannah.

Dr. Howkins was a graduate of the Massachusetts Institute of Technology and of the Physician's and Surgeon's College. In 1920 he began his practice in dermatology and syphilology in Savannah. He soon opened the first free clinic for treatment of venereal disease in Savannah, and operated it for 20 years in conjunction with the city. From 1950-1961, Dr. Howkins served as city physician.

Survivors include his wife, Mrs. Virginia Hewlett Howkins; three sons, John S. Howkins, Jr., of Pascagoula, Miss.; John Huger Howkins of Atlanta, and William B. Howkins of Maine; and a brother, Heyward Guerard Howkins of Cohasset, Mass.

John Charles O'Neill

John Charles O'Neill of Savannah died November 23 after a short illness.

A native of Hartford, Conn., Dr. O'Neill attended the University of Vermont and Holy Cross College and the medical school of the University of Maryland. He moved to Savannah and began his practice in 1920.

Survivors include his wife, Mrs. Birdie Mae Flemister O'Neill; two sons, John C. O'Neill, of Savannah, and Dr. James F. O'Neill of St. Petersburg, Fla.; a sister, Mrs. John G. Foley of East Hartford, Conn.; and nine grandchildren.

WALLACE RESIGNS AS FIELD REPRESENTATIVE

Mr. William V. (Dub) Wallace, Field Representative for the Medical Association of Georgia, has resigned this position effective January 17, 1969. Having been associated with MAG since September, 1966, Mr. Wallace will leave Georgia to enter the publishing business in Montgomery, Alabama.

Prior to his affiliation with MAG, Mr. Wallace served as Executive Director of the Alabama Academy of General Practice and Managing Editor of the organization's monthly publication, *The Alabama General Practitioner*. He later became Executive Secretary of the Medical Association of the State of Alabama, before joining MAG.

In his position as Field Representative, Mr. Wallace worked closely in a liaison capacity between the Medical Association of Georgia Headquarters Office and the Georgia county medical societies.

THE MONTH IN WASHINGTON

A House Ways and Means Committee member introduced on the first day of the new Congress a bill that would provide Federal income tax credits to help individuals buy private health insurance.

The legislation (HR 19), sponsored by Rep. Richard Fulton (D., Tenn.), was similar in principle to a health insurance financing plan utilizing tax credits approved by the American Medical Association House of Delegates at San Francisco last June and reaffirmed at Miami Beach last December.

Fulton said he considered his bill "at least an opener" for hearings. "Certainly before expanding any Federal program, I believe it worthwhile to explore the use of the private sector and our tax system," Fulton said.

Provisions of Fulton Bill

The Fulton bill provides that individuals with incomes of \$2,500 or less and families with incomes of \$5,000 or less would receive \$150 vouchers from the Federal government per eligible individual for the purchase of health insurance. The family maximum would be \$400.

In the case of a taxpayer with an income between \$2,500.01 and \$5,000, or a family with an income between \$5,000.01 and \$7,500, the credit would be a 75 per cent per eligible individual with a maximum of \$400 per family.

In the case of a taxpayer with an income of \$5,000.01 to \$7,500, or a family with an income between \$7,500.01 and \$10,000, the credit would be 50 per cent per eligible individual with a \$400 family maximum.

In the case of a taxpayer with an income exceeding \$7,500.01, or a family with an income exceeding \$10,000.01, the credit would be 25 per cent.

At San Francisco, the House of Delegates adopted as approved AMA policy "the principle of graduated income tax credits for premiums paid for adequate health insurance." A resolution adopted at Miami Beach called upon the AMA to "vigorously promote the enactment of Federal legislation implementing" the plan.

Community Health Care Systems

A special commission on health facilities concluded that government and private enterprise must cooperate to organize the nation's health resources into effective, efficient and economical community systems of comprehensive health care for all persons.

The National Advisory Commission on Health Facilities, established in October, 1967, drafted its report to the President in general terms and did not make any recommendations for legislation.

James Z. Appel, M.D., a former president of the American Medical Association and a commission member, said the family physician would be the ideal "point of entry" to a community health system, but there are not enough of them.

Guiding Principles

A summary of the report included:

"America's health care systems should combine private and public responsibility. Facilities and systems

will vary from community to community in accordance with local capacities and local needs, but guiding principles should govern the effort to develop effective and efficient health care systems:

"(1) These systems should be organized to assure appropriate points of entry into and continuity of health care services.

"(2) Every citizen should have ready access to quality health care.

"(3) States, regions, local communities, and all health institutions should carry out continuous planning.

"(4) Both those who provide and consume health services should participate in the decisions.

"(5) All levels of health care should be interdependent."

Preventive Health Care

A Health, Education and Welfare Department report to Congress recommended that preventive health care services not be added to medicare benefits at this time.

The report cited as reasons for the negative recommendation: administrative constraints, inability to estimate costs, limited experience with automated multiphasic health screening, and an inadequate supply of health professionals.

The report was one of three requested by Congress last year and submitted before the change in Administration.

A second report dealt with coverage of mentally ill under medicare but did not include any recommendations.

Medicare Personnel Qualifications

The third reviewed qualifications of personnel under current medicare regulations. It stated that, because of an acute manpower shortage in the field, physical therapists should be considered qualified if they could establish an adequate level of competency. HEW is developing a proficiency examination.

HEW recommended against allowing licensed practical nurses to serve as nurses responsible for the total nursing care at an extended care facility. It also recommended against changes in the regulations that set minimal standards for independent laboratory personnel.

No Increase in Medicare Plan B

The premium rate for medicare supplementary insurance covering physicians' fees (plan B) will remain at the present rate, \$4 each for the individual beneficiary and the Federal government, until July 1, 1970.

The Johnson Administration's Secretary of Health, Education and Welfare, Wilbur J. Cohen, decided against an increase, although the Social Security Administration's chief actuary had advised that an anticipated rise in physicians' fees called for an increase of 40 cents each for the beneficiary and the government.

Cohen again asked physicians to show "unusual restraint" in setting fees. He urged that physicians and

WASHINGTON / Continued

patients cooperate "in eliminating unnecessary utilization of physicians' services," and asked carriers and intermediaries to carefully review claims during the next 18 months.

FDA Attacks Six Drug Combinations

The Food and Drug Administration proposed that six widely prescribed antibiotic drug combinations be taken off the market on grounds that they fail to live up to their claims of effectiveness.

The drugs and their manufacturers are Albamycin G. U., Albamycin-T capsules and granules, and Panalba capsules, granules and drops—Upjohn Co.; Achromycin nasal suspension—Lederle Laboratories; Mysteclin F capsules, syrup and pediatric drops and Mysteclin F-125 capsules—E. R. Squibb & Sons Inc.

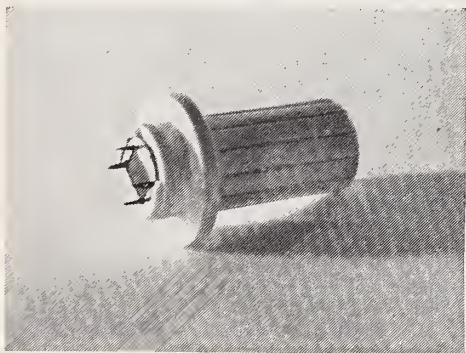
The drug companies were given 30 days to respond before FDA's final action. The FDA order could be appealed to the courts.

Two of the drug companies promptly protested the FDA proposal in public comments. An Upjohn spokesman said his company's combinations are superior to the major constituents alone. A Squibb spokesman said Mysteclin F had wide acceptance among physicians and a proper place in medical practice. A Lederle spokesman said Achromycin was not a major sales product, and declined to comment on what the company's official response would be.

*From the Washington Office
American Medical Association
January 6, 1969.*

To fight TB- find it first!

Make tuberculin testing routine
with every physical examination.



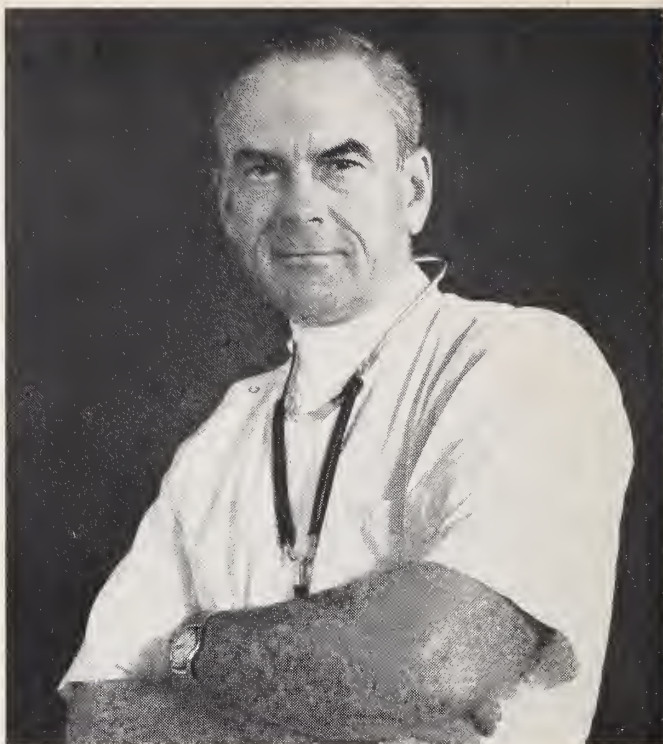
TUBERCULIN, TINE TEST

(Rosenthal)

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HIGHLIGHTS OF EXECUTIVE COMMITTEE OF COUNCIL MEETING, DECEMBER 14, 1968

This summary is being printed so that MAG members may be advised of the actions of the Executive Committee between meetings of Council. It covers only major actions and is not intended as a detailed report in lieu of meeting minutes.

Georgia Symposium on Prevention in Cardiology

—Medical Association of Georgia endorsement of the Georgia Symposium on Prevention in Cardiology was voted. The Symposium is scheduled for May 28-29, 1969, in Atlanta.

Hospital Activities Committee Proposals

—A report was received from the Chairman of the Hospital Activities Committee which included the recommendations that Subcommittees of the Hospital Activities Committee be appointed to consider such subject matter as those functions previously carried out by the Georgia Hospital-Medical Council. The proposal on subcommittees was approved in principle, and the Chairman was asked to propose names for appointment by the Executive Committee.

Regional Conference on Areawide Health Planning

—On hearing a report from President Charles R. Andrews, Jr., M.D., on the Regional Conference on Areawide Health Planning arranged by the Fulton

County Medical Society and held at the Academy of Medicine, Atlanta, on November 22-23, 1968, the Committee voted to send a letter of commendation to the Fulton County Medical Society.

Osteopaths—Attorney William B. Spann reported that while notice of Appeal of MAG's suit to enjoin the Director of the Department of Public Health from paying for drugs prescribed by Osteopaths has been filed with the Georgia Supreme Court, time required for producing the lower Court's record would delay further action until March, 1969. In the meantime, negotiations with the Osteopathic Association and the Board of Medical Examiners have progressed favorably and the Executive Committee agreed to recommend to Council that the attorneys proceed with the drafting of a bill for introduction in the 1969 General Assembly which would create a joint board to license M.D.'s and D.O.'s.

Committee Appointments—Confirmed to serve on the Committee on Medical Review and Negotiating were James E. Pruett, M.D., Atlanta, representing the Georgia Society of Ophthalmology and Otolaryngology; and Floyd C. Cooper, M.D., Decatur, representing the Georgia Psychiatric Association.



for psychiatric treatment

Peachtree Hospital, located in Atlanta, Georgia, is a complete psychiatric, alcoholic and drug addiction treatment facility accredited by the Joint Commission on Accreditation of Hospitals. The hospital has 65 beds, 47 of which are devoted to the care of psychiatric patients

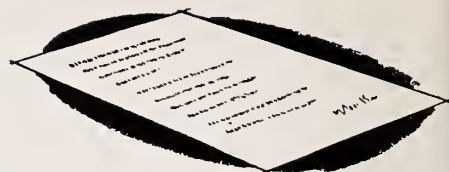
and 18 of which, in a separate area, are for patients with acute cases of chronic alcoholism or drug addiction. Treatment procedures include psychotherapy, electroconvulsive shock therapy, subinsulin coma and chemotherapy. We will be pleased to provide further information upon request.

ACCREDITED BY THE JOINT COMMISSION ON ACCREDITATION OF HOSPITALS

peachtree hospital

41 PEACHTREE PLACE, N. E. / TELEPHONE 873-5681 / ATLANTA 9, GEORGIA

ABSTRACTS BY GEORGIA AUTHORS



Achord, James L., M.D., Dept. of Medicine, Emory U. School of Med., Atlanta. "Acute Pancreatitis with Infectious Hepatitis." *JAMA* 205:837-840 (Sept. 16) 1968.

Four patients had evidence of acute pancreatitis occurring during infectious hepatitis. Paper electrophoresis of serum and urine of one patient revealed migration patterns of amylolytic activity identical to those of saline extracts of the human pancreas. Definite gross and histologic pancreatitis was seen at autopsy in two patients who died of acute fulminant hepatitis. The fourth patient had only mild increases in the level of urine amylase but a classical "reversed 3 sign" on roentgenograms of the upper gastrointestinal tract, that largely disappeared in eight days.

Godwin, John T., M.D., Clinical and Pathological Laboratories, 265 Ivy St., N.E., Atlanta. "Drug Hazards—Sulfobromophthalein Sodium (BSP)." *Southern Med. J.* 61:696+ (July) 1968.

The purpose of this paper is to report upon the hazards of hospitalization and use of drugs. Emphasis is placed upon the infrequent, though occasional, adverse reaction to the use of Sulfobromophthalein Sodium (BSP) in the study of liver function.

It is stated that patients who have an allergic history and those previously given BSP injections have an increased incidence of reaction following BSP injections. (This should be remembered with asthmatic patients.) Reactions usually occur immediately; therefore the physician must be nearby in case of serious reactions in order to administer resuscitation measures, defibrillation and care for other types of reactions. BSP should be given slowly (3-4 minutes for the total dose) and it should be clear—it should not be stored in a refrigerator).

Schroeder, Steven A., M.D., Terry, Pamela M., and Bennett, John V., M.D., Epidemiology Program, National Communicable Disease Center, Atlanta. "Antibiotic Resistance and Transfer Factor in *Salmonella*, United States, 1967." *JAMA* 205:903-906 (Sept. 23) 1968.

Four hundred *Salmonella* strains isolated during 1967 from clinical sources throughout the United States were examined for resistance to 11 antibiotics, and suitable strains were tested for resistance transfer factor (RTF).

Only 89 (22 per cent) of the strains were resistant to one or more of the antibiotics. Resistance was most common to streptomycin (14.2 per cent), tetracycline (12.5 per cent), and sulfathiazole (11.5 per cent). None of the strains was resistant to chloramphenicol, nalidixic acid, or colistin.

Resistance was significantly more

common in strains of *Salmonella typhimurium* than in the other *Salmonella* serotypes. Of 52 multiply-resistant strains, 41 (79 per cent) demonstrated RTF. Comparison with previous studies suggests that no significant change in the incidence of resistant *Salmonellae* has occurred during the past five years.

Tyler, Carl W., Jr., M.D., and Saeger, Armin L., Jr., M.S.W., Family Planning Evaluation Section, National Communicable Disease Center, Atlanta. "Maternal Health and Socioeconomic Status of Nonreservation Indians." *Public Health Reports* 83:465-473 (June) 1968.

This study of nonreservation American Indians living in eastern Oklahoma shows that within the patient population served at a given Public Health Service Indian Hospital, two distinct cultural groups could be identified. The group that functioned socially as Indians was more impoverished, more rural, and had less education than their functionally non-Indian counterparts.

Patients with a lower standard of living had a higher incidence of toxemia of pregnancy, but no relationship between living standard and postpartum infection or anemia was found. Racial and social function, educational attainment, and rural or urban living could not be related to maternal morbidity. Maternity care did not influence the occurrence of either toxemia or anemia, but patients who received no prenatal care had a higher incidence of genital tract infections than those who went to the prenatal clinic.

Cohen, Paul, M.D., Kramer, Norman C., M.D., and Parrish, Alvin E., Communicable Disease Center, 1600 Clifton Rd., Atlanta. "Hyperosmolar Coma: A Medical Emergency." *Medical Annals of the District of Columbia* 37:258-261 (May) 1968.

Hyperosmolar nonketotic coma occurs most frequently in the elderly and is associated with approximately 50 per cent mortality. Salient features include hyperosmolarity due to hyperglycemia, with or without hypernatremia; dehydration; azotemia and the absence of ketosis.

Although the etiology of this syndrome is obscure, patients with intracranial disease of varying etiology are most susceptible. Preexistent hyperglycemia which results in an insidious diuresis, leads to progressive dehydration. Avid salt reabsorption occurs in the nephron, secondary to a marked increase in aldosterone secretion, and may be reflected by low urinary sodium and high potassium excretion, thus indicating an in-tact distal nephron.

Therapy begins with the recognition that this is a true medical emergency, and is directed towards correcting the hyperosmolar state and the complications of dehydration. Intravenous fluids

and insulin are given in large amounts. Half normal saline is generally most efficacious for initial hydration. Central venous pressures should be used to monitor large volumes of fluid replacement, especially if hypotension is present.

Complications include all those known in the severely decompensated diabetic state. Local and generalized infection, arterial and venous thrombosis, hypotension and shock, and tubular necrosis can occur. Focal cerebral seizures, which are often drug resistant, respond to rehydration and correction of the hyperosmolar state.

These observations were based upon a study of three patients with nonketotic hyperosmolar coma and a review of the literature.

Thoroughman, J. C., M.D., Walker, L. G., M.D., and Mann, Charles M. Jr., M.D., Dept. of Surgery, Emory U. School of Med., Atlanta. "Evaluation of Pyloroplasty and Vagotomy in the Surgical Management of Peptic Ulcer." *Southern Med. J.* 61:1227-1230 (Nov.) 1968.

None of the currently employed surgical procedures for duodenal ulcer is free from undesirable side effects. Results in 76 Heineke-Mikulicz and 17 Finney pyloroplasties with vagotomy are analyzed. Dumping and diarrhea occur about as frequently as with other types of ulcer surgery. Weight loss in excess of 5 per cent of the preoperative weight occurred in 40 per cent of our patients having pyloroplasty and vagotomy.

In competent hands, the mortality rate in currently employed procedures for elective surgery is less than one per cent. In over 1,000 cases Weinberg records a mortality rate of 0.2 per cent. In emergency surgery for acute, massive hemorrhage, difference in mortality rate seems related more to the surgeon than to the type of operation employed. Early or late rebleeding after pyloroplasty with vagotomy ranges from one per cent to 36 per cent, much higher than in other types of operations. Recurrence rates are likewise appreciatively higher than occur with resection and vagotomy. Splenic injury occurred in four of 93 of our patients. The overall complication rate was no lower than our series of resection. In our experience a 30 to 50 per cent gastric resection with vagotomy is more satisfactory as a routine procedure.

Smithdeal, Charles D., M.D., Ponce de Leon Infirmary, 144 Ponce de Leon Ave., N.E., Atlanta. "The Significance of Correction of the Anterior Septum in Rhinoplasty." *Southern Med. J.* 61:931-938 (Sept.) 1968.

In nearly every instance of complete rhinoplasty, attention to the anterior nasal septum is required to assure the

desired cosmetic and functional result. The anterior septum must be evaluated in all three planes to insure adequate correction of cosmetic and functional problems. The author offers a classification of abnormalities created by alterations of the nasal septum in each plane. Specific methods of correcting abnormalities in each plane are presented, with accompanying photographs to illustrate each point.

The author's technique for correcting instances of caudal deflection of the septum is presented in detail.

The rhinologist's daily experience in evaluating structural abnormalities of the nose, and devising methods of correction to restore normal physiology must be carried over into rhinoplastic surgery to insure ideal cosmetic and functional results. Careful attention to detail in each of the three planes of the anterior nasal septum is an essential step in obtaining this goal.

Smith, Robert B., III, M.D., Perdue, Garland D., Jr., M.D., and Knowlton, J. Wade, M.D., Joseph B. Whitehead Dept. of Surgery, Emory U. School of Med., Atlanta, "The Treatment of Injuries to the Inferior Vena Cava," *Southern Med. J.* 61:1159-1165 (Nov.)1968.

During the 11 year period from 1956 through 1966, 36 patients were treated for injuries of the inferior vena cava at the Grady Memorial Hospital and the Emory University Hospital:

21 survived. Case histories of these patients have been reviewed and the results of treatment correlated with the location and magnitude of injury and with the method of surgical repair. From this review and from other reports in the surgical literature, a number of principles have emerged for the care of abdominal vascular wounds.

These principles are discussed as they apply to the inferior vena cava. Prompt recognition and aggressive treatment by blood replacement and operation for control of bleeding are necessary if these desperately injured patients are to survive. Repair of the vena cava with preservation of the lumen is essential in wounds above the renal vein level; and repair is definitely preferred to ligation in injuries below the renal vein level. A salvage rate of 60 to 70 per cent can be expected with inferior vena cava injuries if the victim reaches medical attention promptly. Most of the patients who do not survive succumb to associated arterial injuries or trauma to other organ systems.

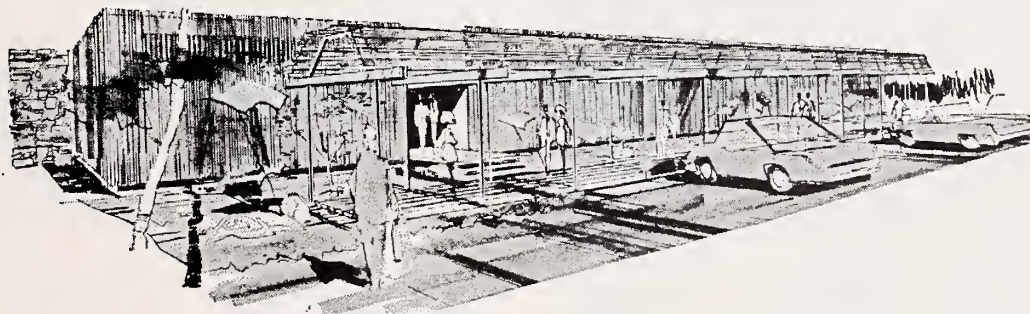
Hagler, W. S., M.D. and Crosswell, Hal H., Jr., M.D., Emory U. School of Medicine, Atlanta, Ga., "Radical Perivascular Chorioretinal Regeneration and Retinal Detachment," *Transactions, Am. Acad. Ophthalmology and Otolaryngology* 72:203-216 (Mar.-Apr.)1968.

The clinical features of a group of 33

patients having a characteristic type of perivascular retinal degeneration were presented. This degeneration usually develops in early adulthood and is commonly associated with presenile cataracts, myopia, open-angle glaucoma, and a "malignant" form of retinal detachment. The degeneration is characterized by clumping of pigment granules around various segments of the retinal vessels, primarily veins. The changes may be quite prominent, but occasionally are subtle and easily missed unless indirect ophthalmoscopy is utilized. In the majority of these patients a dominant familial pattern existed, while the remaining cases appeared to be sporadic.

The authors recommend the prophylactic treatment of retinal tears by either cryosurgery or photocoagulation, but the question of whether all areas of degeneration should be treated has not been resolved. Due to the frequency of subsequent retinal detachment, lens extraction should be deferred as long as possible and all precautions taken to ensure against loss of vitreous. All young patients with unexplained cataracts should have a thorough fundus examination to rule out radial perivascular degeneration.

It is urged that thorough screening of the immediate family of patients with this condition be performed in order that early treatment of other affected members, as well as eugenic counseling, may be made possible.



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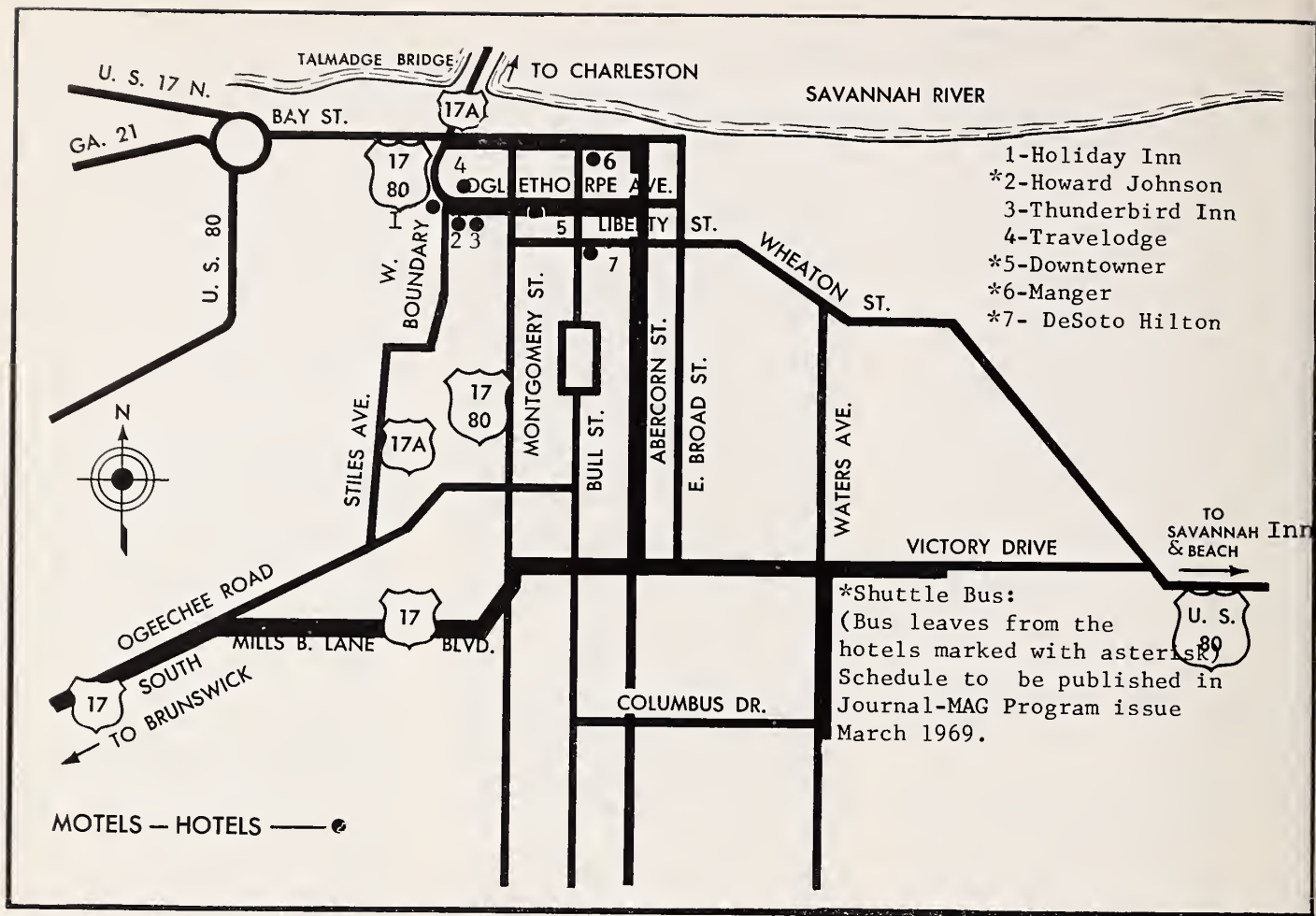
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*Preston D. Ellington, M.D.
Chairman, Committee on Annual Session*

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Medical Association of Georgia, 115th Annual Session
May 4-7, 1969—Savannah, Georgia

A HOUSING BUREAU has been established for your convenience in making hotel and motel reservations at Savannah for the 1969 Annual Session of the Medical Association of Georgia. Comparable room rates and accommodations information are listed. *Use the Reservation Form below.* Please specify your first, second and third choice. All requests should give anticipated date and hour of arrival; date and approximate hour of departure; names and addresses of all persons who will occupy the accommodations. All reservations must be cleared through the Georgia Medical Society, 612 Drayton Street, Savannah, Georgia 31401. Since all requests for rooms will be handled in chronological order, you should mail your application as early as possible, in order to be certain of obtaining your primary choice. All reservations will be confirmed.

- *Desoto Hilton:** Liberty at Drayton Streets (232-0171). Woman's Auxiliary Headquarters. Rates: Single, \$13 to \$18; Double, \$17 to \$22; Suites, One Bedroom, \$38 and up, Two Bedrooms, \$56 and up. 260 Rooms.

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***Downtown Motor Inn:** 201 W. Oglethorpe Avenue (233-3531). Single, double bed, \$11 for one person—\$13 for two. Double, 2 double beds, \$12 for one; \$15 for two. Suites, \$25 and up. No charge for children using same accommodations as parents. 65 Rooms.

Holiday Inn: 121 W. Boundary Street, on U. S. No. 17 at Talmadge Bridge (236-1355). Single, one person \$10; two persons, \$13; Double, one person, \$13, two persons \$15. 75 Rooms.

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Savannah Inn and Country Club: Wilmington Island (897-1612). Headquarters Hotel for meetings, exhibits, social functions, and housing for Council, officers, Staff, Guest Speakers and Delegates as chronologically requested. Shuttle bus will connect with other major hotels. **Modified American Plan (breakfast and dinner).** Single, \$22 to \$29; Double, \$29 to \$44; Suites, \$46 and up. 160 Rooms.

Thunderbird Inn: 611 W. Oglethorpe Avenue on U. S. No. 17 at foot of Talmadge Bridge (231-2661). Single, \$9; two persons, \$12; Double, \$12 and \$14. 20 Rooms.

Travelodge: 512 W. Oglethorpe Avenue, Talmadge Bridge, off U. S. No. 17 (233-9251). Single, \$10, two persons, \$13; Double, \$9 for one person, \$11 for 2 persons: \$2 for each additional person. 20 Rooms.

Confirmation of your request for accommodations will be in accordance with preference indicated, if possible; if not, best substitutes will be made.
*Shuttle bus will operate from this hotel to Savannah Inn and Country Club. Schedule will be published in March 1969 issue of JOURNAL MAG.
If you wish to stay at Tybee Beach, please indicate on reservation form and Housing Bureau will arrange.

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Arrival Date	Hour	A.M.	P.M.
Departure Date	Hour	A.M.	P.M.

THE NAME OF EACH HOTEL GUEST MUST BE LISTED. Include all names of all persons for whom you are requesting reservations and who will occupy space.

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Individual Requesting Reservations

Name

Address

City State

Zip

If hotels or motels of your choice are unable to accept your reservations, the Housing Bureau will make reservations to fit your specifications elsewhere.

ELECTRONIC PROGRAM DEVELOPED FOR CONTROL OF CHRONIC DISEASES

The Medical College of Georgia and the National Cash Register Company together have developed a computerized system for monitoring and analyzing the incidence of tuberculosis and other communicable diseases within a given State or smaller community. The system is the product of two man-years of programming effort.

Current Projects

Under the direction of Dr. Rufus F. Payne, the Medical College's Division of Hospital Research and Development is actively exploring the application of the computer to the solution of medical problems. Current projects include:

- The development of a medical audit system for hospitals. Under this system, the computer will analyze the utilization of facilities, the quality of care, the value of established procedures, the effectiveness of antibiotics under different conditions, the normal delays in making space available for different groups of patients, and so on.

- The development of computerized medical records for out-patients of a hospital or large clinic. These records will provide any staff doctor or dentist who must refer to them a current and comprehensive picture of the patient's condition. The investigation is expected to reveal what the format of the records should be, how frequently they should be printed out by the computer, and whether the costs of maintaining such records can be justified. At the present time, the study is concentrating on the records of pediatric and pre-natal patients.

- A complete patient information system for hospitals, a long-range, large-scale project that will include many sub-projects.

- A control system which is designed to be used in long term management of any type patient, but is particularly useful in communicable disease control. Of the four projects this one has been the most thoroughly tested and is currently in operation in Richmond County (Augusta), Georgia, and Aiken County (Aiken), South Carolina, with records now being abstracted for the inclusion of patients in other nearby counties.

Information Stored by Computer

Under the system, every person who is identified by a doctor or a clinic or other source as having experienced some degree of risk, either in terms of contact or of actual disease, is registered by the Control Registrar. The basic information on each patient is written in a standard form which organizes it for entry through a series of punched cards into the computer. The process of filling in the form requires about two minutes for a new case and an average of ten minutes for a case with a treatment history. This information is stored in the computer's magnetic file for regular review and analysis.

The computer prepares new case and contact report lists and investigation requests on a weekly basis.

These listings, broken down by locality, are sent to field investigators, public health nurses and others responsible for locating and investigating new cases.

Treatment Schedules Established

After a case has been entered into the system, action is begun to cure the patient and protect his contacts. Appointment letters, informing the patient and the contacts that they are scheduled for an examination, are written by the computer. These may be either the initial examination letter or periodic reminders of regular check-ups once the patient begins treatment. As the letters are written, schedules are established for the various treatment centers.

The scheduling of the facilities is completely maintained by the system with allowance for STAT changes by physician, lab, or clinic. All data pertinent to examination, treatment, and drug scheduling is stored in the magnetic files. If the forms provided to the clinic for the recording of test results, treatments, and drug prescriptions, are not returned within the stipulated time, the system reports the patient as delinquent.

Under a manual system, the scheduling of tests and examinations is ordinarily a tedious operation requiring the attention of a medically competent individual, usually a doctor or a nurse. A TB nurse may spend 20 per cent of her time reviewing records.

Under this electronic system, the computer can review and update 500 patient records—including the preparation of schedules and the writing of the appointment letters and reports on the 500 patients—all within 12 minutes. The system frees the doctor or nurse for more demanding medical functions. Furthermore, the computer applies a rigid set of criteria to produce consistent results under all conditions.

System Is Not Inflexible

However, the system is not inflexible. The physician always has the options of altering or cancelling the computer-generated schedule by manual scheduling when he feels he should.

After a patient keeps an appointment, the treatment center enters the results in the turn-around documents provided by the computer center. Any change in status, stage of disease, treatment rendered, X-ray results, lab results, drug pick-up, type of drug and quantity dispensed, next appointment date, or other information pertinent to treatment and cure are entered in the appropriate forms and returned for entry into the computer. This information is used to update the records in the magnetic file.

Records Periodically Updated

As the records are periodically updated and reviewed, the system supplements the action documents, such as the appointment letters, with the management reports needed for direction and enforcement. For example, the computer automatically checks the appointment portion of each patient's record and ac-

cumulates the information necessary to print out a delinquency list for remedial action. A status change which results in the discharge of the patient triggers the transfer of his records from the active file to printed registers and off-line magnetic storage for later research, special surveys and other studies. Lab results, X-ray results, and other tests generate letters to

the patient and his physician. Drug usage is calculated from the amount previously dispensed and the exhaustion date to determine if the patient takes the drugs as prescribed. If he does not, his name is included in a report so that steps can be taken to explain the necessity for more rigid adherence to the treatment program established for him.

MAJORITY OF GEORGIA DEATHS DUE TO HEART DISEASES

During 1967, more than half (52.6 per cent) of all deaths in the State of Georgia were due to cardiovascular diseases. Specifically, of the 28,448 Georgians who died in 1967, 20,235 of them died from heart disease.

In the five-county metropolitan area, i.e., Fulton, DeKalb, Gwinnett, Clayton and Cobb counties, the total number of deaths from heart diseases in 1967 was 6,633, or 1,918 more than in 1966.

According to Simone Brocato, M.D., Columbus internist and President of the Georgia Heart Association, "One is keenly and painfully aware of these vital statistics, aware that heart diseases kill more Georgians than any other cause." Dr. Brocato noted that the Georgia Heart Association is made up of a body of physicians and volunteers numbering in the

thousands, who all believe strongly in the objectives of the Heart Association.

"It's up to all of us to help the Heart Association in its fight against this ferocious killer," Dr. Brocato said. He commented on the fact that the Heart Association pours funds into research, education and community service yearly, and that the preventive measures outlined by the Heart Association for the public are rules of common sense and safety.

There were 17 fewer deaths in 1967 in the State of Georgia, from all causes. But there were 165 *more* deaths from heart disease in 1967 than there were in 1966. "We must batter away at these statistics," Dr. Brocato said. "We owe it to the thousands of volunteers and scientists who have dedicated themselves and their talents to the Heart cause, but most of all we owe it to ourselves. We help the Heart Fund, and we help our hearts."

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EMERGENCY MEDICAL SERVICES DURING CIVIL DISTURBANCES

The following statement was approved by the Committee on Trauma at its annual meeting, held in Toronto, January 26 and 27, 1968. Since this statement was prepared by the Subcommittee on Disaster Surgery, questions should be referred to its chairman, Francis C. Jackson, Veterans Administration Hospital, University Drive, Pittsburgh, Pa. 15240.

The Committee on Trauma of the American College of Surgeons recognizes that effective performance of emergency medical services during civil insurrection or riots may be seriously hampered by the special circumstances encountered. The Committee, therefore, urges that the membership of the College and its committees on trauma located in communities where civil strife can develop should be cognizant of certain information and recommendations relating to medical and hospital practice during these particular emergencies.

Background Information

The communities and hospitals involved with civil disturbances in recent years have usually had an adequate warning of the developing emergency. Several days may elapse before a serious phase evolves and large numbers of casualties occur. There is a gradual increase in the severity of such injuries, so that by the third or fourth day the largest number of casualties may be treated. A majority of those severely injured may be admitted within a few hours during one evening.

The most difficult problems faced have been related to loss of telephone communications; inability of staff and personnel to reach the hospital; difficulty in providing information to the press and relatives; lack of security and police protection; difficulty in establishing the location and providing for "prisoner" patients; lack of an identification system for hospital personnel and volunteer representatives from supporting community agencies; shortage of certain food items and other limited inventory supplies; difficulty in delivery of such supplies and, finally, problems related to regular emergency services for patients not involved in the disturbances.

Recommended Action

It is therefore recommended that the following steps be taken by responsible leadership of College members on local committees on trauma where civil disturbance may be threatening.

Within the Community

(1) Request and support a co-ordinated effort among physicians, i.e., the established disaster committee of the component medical society, the hospital association and the local government.

(2) Propose the establishment of an emergency medical operations center or information center staffed by knowledgeable physicians and others which is

closely associated with the community emergency headquarters (or its communications center) for coordination of the hospital and medical services and the provision of health manpower and supply needs.

(3) Establish hospital reception centers for casualties with particular reference to security requirements for these institutions, particularly access from them to controlled traffic routes. In addition, identify hospitals which are to act as "back-up" or support units for the provision of general and nonrelated emergency medical care.

(4) Establish an identification system for physicians and health personnel.

(5) Establish secure traffic routes and alternate routes to hospitals for ambulance services and health personnel.

(6) Establish resupply procedures between hospitals and regular sources of medical supplies, drugs and vaccines.

(7) Suggest that the public be notified at a time agreeable to authorities of the plans and services to be assigned to each hospital.

Within the Hospital

Review and update disaster plan with particular reference to the following:

(1) Security within the building and grounds.

(2) A communications system, i.e., radio, telephone and messenger services, or the establishment of closed telephone circuits to the emergency medical operations center and other hospitals.

(3) Evacuation of wards nearest emergency department or convenient to operating suite.

(4) Selection of ambulance entry and sorting center easily secured from outside interference.

(5) Notification, deployment, rotation and quartering of all personnel.

(6) Establishment of a security ward for patients under confinement or arrest.

(7) Restriction of visitors for the duration of the disturbance.

(8) Development of an effective identification system for volunteer personnel, clergy and others.

(9) Arrangement for the regular or systematized release of bulletins of information for representatives of the news media.

(10) Review by the medical staff of principles to be utilized for medical care of ambulatory patients and particularly casualties with penetrating wounds of cavities.

(11) Briefing the staff on the effects of tear gas—CS, NC or MACE.

(12) Insuring that records indicate the exact details of all wounds and mechanisms of injury. All missiles should be carefully retained and identified.

(13) Establishing policies for the use of drugs, antibiotics, tetanus prophylaxis and treatment of shock.

(14) Plan for care of unexpected emergencies not related to the civil disturbance.

Summary

Experiences in the hospital management of casualties from a civil riot suggest that this catastrophe is

not a disaster in the usually accepted sense. Nevertheless, considerable planning is necessary.

Patients will arrive sporadically and the majority may appear during one evening.

While operating rooms and other facilities are rarely taxed, judgment in the identification and assignment of personnel and procedures to be practiced should be reviewed.

Emphasis in planning should be related to communications, internal and external security, identification and relief of personnel, care of an incarcerated population, careful records, and resupply of certain limited inventory items.

An effective co-ordination of hospital services with the total emergency response within the community is absolutely necessary.

REPORT ON THE SOUTHEASTERN REGIONAL CONFERENCE ON AREAWIDE HEALTH PLANNING

Charles R. Andrews, Jr.

President, Medical Association of Georgia

Several of us attended the Regional Social Security Secretary's Conference on Health Care Costs held at Executive Park Motel on October 4 and 5, 1968, where great emphasis was placed on the need for the medical profession to become more deeply involved in Comprehensive Health Planning Conferences in their area. One immediate outgrowth of that emphasis was the creation of the Southeastern Regional Conference on Areawide Health Planning by our enterprising colleague Bill Dowda of Atlanta. This Conference, held on Friday and Saturday, November 22 and 23, 1968, at the Academy of Medicine, followed the same general format of the Secretary's Conference, with formal presentations in the opening sessions each day, followed by workshop groups with leaders who reported to the assembly on their discussions.

Conference Speakers

The meeting was keyed by Dr. Linton Bishop, and included on the program were Congressmen Fletcher Thompson and Phil Landrum; Dr. Charles

Hudson, Director of AMA's Health Services Division; Dr. Joe English, OEO Assistant Director for Health Affairs; Dr. Noah Langdale, President of Georgia State; and Dr. John Cashman, Assistant Surgeon General and Director of HEW's Community Health Service.

Subjects included in both the formal remarks and the discussion groups centered around the role of each agency or segment of the profession represented in Health Planning. Such subject areas as formation of planning agencies, personnel, prepayment, facilities for the future, environmental health hazards, and group practice were covered in the discussions.

Report Being Compiled

A complete report of the meeting, with copies of prepared remarks, is now being compiled by the Fulton County Medical Society and should be available soon. One immediate result of this Conference will be MAG's efforts toward identifying the major medical market areas in Georgia and assisting the profession through the County Medical Society officers in those areas to become involved in Areawide Health Planning and to take advantage of Federal grants available.

COURSE OFFERED IN LARYNGOLOGY AND BRONCHOSOPHAGOLOGY

The Department of Otolaryngology of the Illinois Eye and Ear Infirmary and the College of Medicine of the University of Illinois at the Medical Center will conduct a postgraduate course in Laryngology and Bronchoesophagology from April 14 through April 25.

This course is limited to 15 physicians and will be under the direction of Paul H. Holinger, M.D. It will be held largely at the new Illinois Eye and Ear Infirmary, 1855 West Taylor Street, Chicago, and will

include visits to a number of Chicago hospitals. Instruction will be provided by means of animal demonstrations and practice in bronchoscopy and esophagoscopy, diagnostic and surgical clinics, as well as didactic lectures.

Interested registrants may write directly to the Department of Otolaryngology, College of Medicine, University of Illinois at the Medical Center, Post Office Box 6998, Chicago, Illinois 60680.

CALL FOR SCIENTIFIC EXHIBITS

115TH ANNUAL SESSION OF THE MEDICAL ASSOCIATION OF GEORGIA

Savannah, Georgia, May 4-7, 1969

For Information and Applications, Write:

John McClure, Jr., M.D., Chairman, MAG Scientific Exhibits Committee
938 Peachtree Street, N.E. • Atlanta, Georgia 30309

COMPREHENSIVE HEALTH PLANNING IN GEORGIA

*Eugene J. Gillespie, M.D., Director
Georgia Office of Comprehensive Health Planning*

During recent months the health industry of this country has entered an era of unprecedented emphasis upon planning. It is largely an uncharted course that we follow but one, nonetheless, that holds much promise. Progress in meeting the health needs of Georgians depends upon careful planning. The term "comprehensive health planning" is the one most commonly used in referring to this new course. In broadly viewing the involvement of the health care system in America, which has been characterized by tremendous and complex growth, the concept of "comprehensive health planning" and its practical application become a relevant step forward in further progression toward evolution of this system.

Cooperative Planning Endeavor

Although there is no single definition of comprehensive health planning agreed upon by all involved in the concept's implementation, there are some basic elements that receive general acceptance. In one instance, comprehensive health planning has been analogized to a large "umbrella" under which all health planning efforts take place.

This thought automatically suggests that in order to be meaningful and to produce a significant end product, the planning process itself must not be an isolated one setting itself apart from other closely related interests and activities. Rather, it encompasses these in a coordinated and cooperative planning endeavor. In this sense, comprehensive health planning should become the umbrella of coordination at the community and State levels. Certainly, without such coordination and cooperation we run the risk of planning inadequately to solve today's health problems and meet tomorrow's health needs.

The application of sound planning principles and methods to community and state-sized health problems is basically but another step upward from much of the planning that has been done for so many years within hospitals, physicians' offices, and voluntary, private, and public health agencies. Certainly, when an agency decides to alter its structure by adding, modifying, or deleting a particular unit, it must first envision how such action will affect the whole of the organization. When it does not do this, it takes certain risks. Why then should we not also apply these same sound planning principles and procedures at the community and State level for the betterment of our health care system and, moreover, for the betterment of the health of the people which that system serves? When this is done, then we can say that the concept of comprehensive health planning is at work.

Georgia established a State mechanism for comprehensive health planning shortly after the President signed Public Law 89-749. This measure is known as the "Comprehensive Health Planning Act," but is often referred to as the "Partnership for Health Act." Basically, this legislation's provisions appropriated Federal monies to support health planning mechanisms at the State and local levels.

Program Established in Georgia

The Georgia Department of Public Health was designated by the Governor as the comprehensive health planning agency for the State. To carry out this responsibility, the Office of Comprehensive Health Planning was established. This office has the responsibility of comprehensive state-wide planning in health, providing consultation to individuals and groups requesting help, as well as providing staff support to the Advisory Council.

Advisory Council Appointed

Governor Maddox, on November 1, 1967, appointed a 25-member advisory body known as the Georgia Comprehensive Health Planning Council to advise the Georgia Department of Public Health and the Office of Comprehensive Health Planning. Initially, one-third of the councilmen were appointed for a one-year term, one-third for a two-year term, and one-third for a three-year term. All subsequent appointees will serve three-year terms. Over half the membership were users of health services; the remainder were health professionals. The Council's membership also includes representatives of non-governmental health organizations, governmental agencies, and consumer representatives. As its first chairman, the Council named Dr. Thomas J. Anderson, a practicing internist from Atlanta.

Purpose of the Council

As outlined in its Bylaws the Advisory Council's purpose shall be "... to identify health problems and needs; to set and periodically revise goals and objectives toward which governmental and non-governmental health and related agencies and groups can strive cooperatively; to promote the efficient utilization of resources; and the development and expansion of resources where needed; and to assure that current and future health manpower, services, and facilities for prevention of disease and injury and for health care, will be coordinated with one another and with those of welfare, education, vocational rehabilitation, and other activities that affect environmental, physical, and mental health."

At present, Council members serve on four standing committees which meet periodically. These committees, which are health manpower, health services, health facilities, and community organization and health education (areawide planning), have several functions which include proposing the necessary action needed to achieve the Council's purposes and to make recommendations concerning special matters of interest to the Council.

Multi-County Planning

One section of P.L. 89-749 provides for the development of comprehensive regional, metropolitan area, or other local area plans for coordination of existing and planned public and private health services, including the facilities, manpower, and funds.

required for the provision of such services. It is anticipated that areawide planning will be organized in the State on a multi-county basis encompassing the major medical trade areas of Georgia. Through interstate cooperation, bi-state areas will be developed where patterns in the delivery of health services transcend State boundaries.

Within this framework of areawide comprehensive health planning, it is hoped that coordinated long-range planning for health needs can be carried out so that an optimum of quality health services will be available to a maximum number of the people.

Physicians Encouraged to Participate

A number of efforts are being made presently throughout Georgia among local leaders in health regarding the development of areawide planning. Physicians are strongly encouraged to participate in such planning endeavors in their areas.

The climate in which P.L. 89-749 is intended to be implemented can best be described by quoting the measure's own declaration of purpose, which is as follows:

"The Congress declares that fulfillment of our national purpose depends on promoting and assuring the highest level of health attainable for every person in an environment which contributes positively to healthful individual and family living; that attainment of

this goal depends on an effective partnership involving close intergovernmental collaboration, official and voluntary efforts, and participation of individuals and organizations; that Federal financial assistance must be directed to support the marshaling of all health resources—national, State, and local—to assure comprehensive health services of high quality for every person, but without interference with existing patterns of private professional practice of medicine, dentistry, and related healing arts."

New Opportunities Emerging

In conclusion, we see emerging today in the health care system of our State and country new opportunities, many of which are not yet fully developed. These opportunities have been created as a direct result of the expressed interests and concerns of both professional and lay health leaders at all levels, and in all sectors, of health activity. It remains to each of us to utilize these opportunities to the extent that we can make, through more effective planning capabilities, better utilization of our existing health resources, whether they be manpower, services, or facilities, and to develop the new resources that are needed to provide the citizenry of this State the best health care system attainable. Such a system, it seems, can only be achieved when joint and coordinated planning efforts become an everyday occurrence rather than a much idealized vision.

MAG'S NEW HEADQUARTERS: A PROGRESS REPORT



Builders had to find a way to build a wall against pressure in constructing the new Headquarters building. Supports were welded (left) every eight feet at problem points. With the side walls progressing, forms are placed (right) for pouring of concrete center supports.

EMORY GETS GO-AHEAD FOR INTERNATIONAL NURSING CENTER

Emory University has decided to go ahead with development of an International Nursing Center at Emory's Nell Hodgson Woodruff School of Nursing, following endorsement of the plan by six major religious organizations involved in overseas health programs. Dean Ada Fort of the nursing school said that a number of special pilot-type program offerings will be made to American and foreign nurses with overseas commitments, hopefully by the beginning of fall quarter 1969.

Plan Endorsed by Churches

Dr. Fort said the plan was "enthusiastically endorsed" at a meeting on the Emory campus in December by representatives of the United Methodist Church, Southern Baptist Convention, Seventh-Day Adventists, Presbyterian Church in the U.S., The United Presbyterian Church in the U.S.A., and the National Council of Churches.

Also concurring in the idea were officials who were present from the Office of International Health of the Department of Health, Education and Welfare, Washington, D.C., and the International Affairs Office of the National Communicable Disease Center in Atlanta, Dr. Fort said.

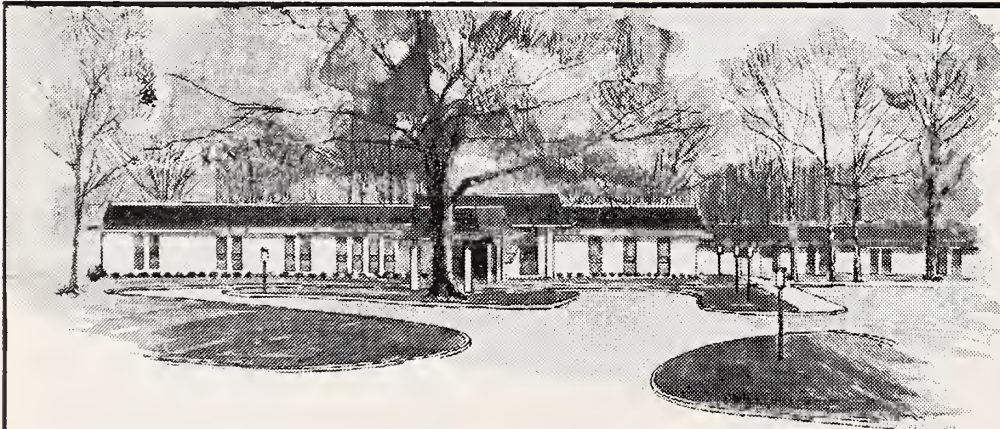
Initial planning funds of \$15,000 have been allotted to the project by the Board of Missions of the United Methodist Church.

Dr. Fort said that one of the reasons why Emory feels a responsibility to become involved in international health education is that no nursing education center now exists in America or in the world which can provide an adequate nursing program for nurses employed outside the U.S. in church-related health services.

Two Major Goals

She said the two major efforts of the Emory program—when it becomes fully operational—will be "(1) the training of American nurses to serve overseas, and (2) the education of foreign nurses to practice in their homelands in an atmosphere permeated by the principles and influences of the Christian religion."

The new International Center will be created as a special division within the established framework of the Emory School of Nursing, and the director of the center will be responsible to the dean of the School of Nursing, Dr. Fort explained.



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EXPERIMENTAL PROGRAM STARTS FOR "PEDIATRIC ASSOCIATES"

Two of the nation's larger philanthropic foundations, Carnegie Corporation of New York and the Commonwealth Fund, recently announced support of an experimental program to prepare a wholly new type of professional practitioner in medicine: a Pediatric Associate who, working under the supervision of a physician, will be qualified to examine and immunize well children and treat the more common childhood diseases.

Ease Burden on Pediatricians

The purpose of the project is to demonstrate one new method of providing more and better care to our nation's burgeoning child population in spite of the national shortage of pediatricians and others who care for children. The project will be conducted by the University of Colorado School of Medicine, under the direction of Dr. Henry K. Silver, Professor of Pediatrics and chief architect of the new curriculum. Graduates of the program will receive a Bachelor of Arts degree from the University of Colorado.

The two foundations are supporting the effort in approximately equal amounts, with three-year grants to the School of Medicine totaling \$450,000. The School has also received a \$73,179 grant from the Bureau of Health Manpower for the first of three years' support.

The curriculum for the Pediatric Associate was originally planned under a previous grant by Carnegie Corporation and is an out-growth of an experiment supported by Commonwealth Fund to train a new type of nurse—the pediatric nurse practitioner.

In a joint statement announcing the grants, Alan Pifer, President of Carnegie Corporation, and Quigg Newton, President of the Commonwealth Fund, said: "Authoritative studies of the outlook for medical care in the United States, such as the Report of the National Advisory Commission on Health Manpower, have concluded that the country will face a severe shortage of physicians for some years to come. Our two foundations agree that serious efforts must be undertaken to help doctors make the best use of their time, knowledge, and skill.

New Category of Health Professional

"For this reason, we are persuaded that the experimental curriculum that has been designed by the University of Colorado School of Medicine is of considerable national importance. It is focused on pediatric care—an area of medicine in which the burdens of practice are especially heavy—and it is intended to demonstrate that, with appropriate education and certification, a new category of health professional can be qualified for employment by doctors to assist them with specific aspects of their responsibilities that are now carried out by the doctors themselves and that consume much of their time and energy.

"The Carnegie Corporation and the Commonwealth Fund are deeply impressed by the interest and support this planned experiment has received from all levels of the Colorado medical community, and we are pleased to share this endorsement of an educational innovation that could have far-reaching benefits to

physicians and to the infants and children within their care."

Role of Pediatric Associate

The responsibilities envisioned for graduates of the curriculum—who will be termed Pediatric Associates—are based not on the nursing role but on the physician's role. Hence, the Associate will have a substantial degree of medical responsibility for the physician's patients.

The Associate will make diagnoses and decide on and carry out appropriate measures for treatment. This will include the writing of prescriptions—exclusive of narcotic compounds—from an approved list of drugs. Thus, the Associate will be equipped to take part in all dimensions of the physician's practice. The same wide level of responsibility will apply to Associates employed under doctors in the public-health services.

Limits Clearly Defined

The limits of the Associate's medical-practice activities, however, will be clearly defined both legally and professionally.

With the backing of the Colorado State Medical Society, the State Chapter of the American Academy of Pediatrics, and other responsible medical bodies, legislation has been proposed setting forth the terms governing the required education and permissible scope of activities of this new health professional. The legislation will require that graduates of the Associates curriculum be examined and certified by the Colorado State Board of Medical Examiners.

Two Major Safeguards

In their professional role, certified Associates will function within two chief safeguards. First, each Associate will serve under the personal direction and supervision of a particular physician, who will review the Associate's work and be available for consultation at all times.

Second, the Associate will spend his time on well-child care—scheduled physical examinations and immunizations, for instance, and routine hospital care for the newborn infant—and on minor ailments and injuries that are a normal part of childhood. These include certain respiratory ailments, various communicable and infectious diseases, accidental injuries, gastrointestinal disturbances, allergy problems, and mild skin disorders. The more acute illnesses will be handled directly by the physician, and the Associate will be trained to recognize abnormal symptoms so that such cases can be detected early and placed in the physician's care.

Even within these limits, the Associate should be able to give medical care to about 80 per cent of the patients within the typical pediatrician's practice. This would provide the physician with more time to devote to seriously ill children, and to keep abreast of advances in his field.

PEDIATRICS / Continued

The experimental curriculum has been designed to lead to professional qualification five years after high school, including a year of internship. It is a joint program between the University's main campus in Boulder and the School of Medicine in Denver. The University and the School have assigned leadership in the effort to the Department of Pediatrics, and an advisory committee with representation from Colorado medical societies and State and local government health agencies has been appointed to guide the Department in development of the curriculum.

Undergraduate Curriculum

Students interested in the program will spend their first two years of the five-year course at Boulder—or other undergraduate schools of their choice—taking liberal arts offerings and essential premedical studies, such as organic chemistry, biology, and mathematics. Dr. Silver, director of the program, and other faculty will keep in touch with them during this period, working with the student-counseling staff of the University of Colorado and conducting seminars on broad aspects of medical practice.

Students accepted for training as Pediatric Associates will transfer to the University of Colorado Medical Center for three years of intensive professional education, which will comprise two years of academic and clinical education leading to the bachelor's degree, plus an internship year.

Studies in Basic Sciences

The first year of the professional-education phase will be devoted to a concentrated, 48-week sequence of studies in the basic sciences. The emphasis here will be on the relevance of these fields to understanding both the normal and the disease states of physiological systems. For example, anatomy and physiology will be combined in the study of the cardiovascular system, and then be followed by combined studies of heart and vascular pathology and related clinical diagnoses.

Clinical Training

The second year, also 48-weeks, will be devoted to fundamental clinical training and will consist of a clerkship experience similar to that provided for medical students. Along with medical students, the students in the Pediatric Associate course will gain experience in history taking, performing complete physical examinations, and in ordering, carrying out, and evaluating pertinent laboratory studies. They will also participate with medical students in departmental conferences, seminars, and rounds. The main difference between the Pediatric Associate clerkship and the medical-student clerkship is that the Associate's training will concentrate largely on the elements of health care as limited to children and will give particular attention to ambulatory pediatrics.

Internship Training

These emphases will also characterize the Associate's internship training, the final year of professional education. For this purpose a broad array of teaching settings are available—including not only the out-

patient departments and special clinics of the University's Medical Center and of the Denver Department of Health and Hospitals, but also sizable O.E.O. Neighborhood Health Centers and their satellite health stations.

In addition, during their internship, the students in the Associates course will train in the offices of pediatricians in private practice, who will serve as their preceptors.

Another chief feature of the Associate's professional education will be attention throughout the course to child development and growth, and family and community life as they affect behavioral patterns in health and illness.

Plans for Implementation

The University and the School of Medicine will begin the program on a limited basis in the fall of 1969 by admitting a pilot class of eight to ten students to the three-year professional-education phase. This would mean that the first group of Pediatric Associates could be qualified for practice by the summer of 1972.

Subsequent pilot classes will not be increased much beyond the size of this starting group, until the faculty has acquired sufficient experience with the new teaching program to permit larger enrollments.

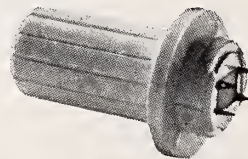
The grants from Carnegie Corporation and the Commonwealth Fund will be used primarily toward the costs of the professional and administrative staff responsible for conducting the experiment, and toward the costs of the teaching staff. The latter will be drawn from basic-science and clinical departments from throughout the School of Medicine, and will devote about a third of their total time to the experiment.

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CALENDAR OF MEETINGS

In Georgia

- February 18-22, 1969—American College of Radiology, Regency-Hyatt House, Atlanta.
 February 23-26—Atlanta Graduate Medical Assembly, Regency-Hyatt House, Atlanta.
 March 6-7—Symposium on "Progress of Man Toward the Year 2000," Sponsored by the Cobb County Medical Society and Kennesaw Junior College, Kennesaw Junior College, Marietta.
 March 14-15—American Burn Association, Regency-Hyatt House, Atlanta.
 March 15—AMA Regional Workshop for State Chairmen of Committees on Medicine and Religion, Air Host Inn, Atlanta.
 March 27-29—Southern Society of Anesthesiologists, Marriott Motor Hotel, Atlanta.
 April 7-9—Postgraduate course on "Pharmacology for the Anesthesiologist," Emory University, Atlanta.
 May 4-7—115th MAG Annual Session, Savannah Inn and Country Club, Savannah.

National

- February 18-20—International Conference on Rubella Immunization, National Institutes of Health, Bethesda, Md.
 February 21-22—Postgraduate Continuation Course in Gastroenterology, Del Webb Towne House, Phoenix, Ariz.
 February 20-22—Central Surgical Association, Drake Hotel, Chicago, Ill.
 February 24-26—American College of Surgeons, Sectional Meeting, Brown Hotel, Louisville, Ky.
 February 26-March 2—American College of Cardiology, New York Hilton, New York, N.Y.
 March 2-5—International Anesthesia Research Society, Americana Hotel, Bal Harbour, Fla.
 March 2-7—Ocular Pharmacology and Therapeutics, Roosevelt Hotel, New Orleans, La.
 March 5-7—Symposium on Fundamental Cancer Research, "Genetic Concepts and Neoplasia," Shamrock Hilton Hotel, Houston, Tex.
 March 6-8—International Conference on Children with Learning Difficulties, Convention Center, Fort Worth, Tex.
 March 7-13—American Association of Pathologists and Bacteriologists, San Francisco Hilton, San Francisco, Calif.
 March 9-12—Society of Toxicology, Lodge Hotel, Williamsburg, Va.
 March 10-13—New Orleans Graduate Medical Assembly, Roosevelt Hotel, New Orleans, La.
 March 11-15—International Academy of Pathology, Hilton Hotel, San Francisco, Calif.
 March 13—AMA Council on Mental Health, Drake Hotel, Chicago, Ill.
 March 13-15—AMA-ABA National Medicolegal Symposium, Caesar's Palace, Las Vegas, Nev.
 March 13-15—"Current Problems in Electroencephalography: Advances Toward Their Solution," Houston, Tex.
 March 14-15—Conference of State Mental Health Representatives, Sponsored by AMA Council on Mental Health, Drake Hotel, Chicago, Ill.

- March 14-15—American Association of Obstetricians and Gynecologists (Mid-winter clinical meeting), Olympic Hotel, Seattle, Wash.
 March 15-19—American Academy of Allergy, Americana Hotel, Bal Harbour, Fla.
 March 19—Council on Rural Health, Sponsored by AMA Department of Health Education, Marriott Motor Hotel, Philadelphia, Pa.
 March 19-23—Sixth Annual Institute on Diabetes, Sponsored by Colorado Diabetes Association, Aspen Institute, Aspen, Col.
 March 20—Meeting for State Medical Association Rural Health Committee Chairmen, Marriott Motor Hotel, Philadelphia, Pa.
 March 20-22—American Academy of Facial Plastic and Reconstructive Surgery, The Royal Orleans, New Orleans, La.

ACP SPONSORS COURSE ON GASTROENTEROLOGY

The American College of Physicians presents "Three Days of Gastroenterology," March 26-28, 1969, at Grady Memorial Hospital Auditorium.

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A combination of lectures and patient-oriented panel discussions, followed by question and answer periods will be the structure of the course. Selected portions of the course will be placed on video tape and played back in the evening for those who might have missed the daytime presentation, or who wish to hear and see them again for review. An outline of most presentations will be made available for registrants in booklet form.

The director of the course is John D. Galambos, M.D. All registrations, requests for information and application blanks should be addressed to Edward C. Rosenow, Jr., M.D., F.A.C.P., Executive Director, American College of Physicians, 4200 Pine Street, Philadelphia, Pa. 19104.

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Cover

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115th Annual Session Official Call

Extended to All Officers and Members of the Medical Association of Georgia

THE OFFICIAL CALL for the 115th Annual Session of the Medical Association of Georgia is hereby extended to all Association members. This four-day meeting will be convened May 4, 5, 6, and 7 at the Savannah Inn and Country Club, Savannah, Georgia. The Association will conduct scientific sessions and general business meetings, and the House of Delegates will be convened for their annual meeting. Scientific and Commercial exhibits will be on display in Ballroom A and the Wilmington Room at the Savannah Inn adjacent to the main meeting room. Social events for the membership have been planned and many of the Specialty Societies will have their own luncheon and dinner meetings. The Woman's Auxiliary to the Medical Association of Georgia will hold their 44th Annual Convention in conjunction with the Association Annual Session at the DeSoto Hilton Hotel.

Registration

The MAG Official Registration Desk will be located in the Exhibit Area Entrance of the Savannah Inn. The Ballroom A and the Wilmington Room will serve to house the MAG Scientific and Commercial Exhibits and will be used as the entrance and exit to the Ballroom B and C which are the main meeting room for the session. Other meetings will convene in the St. Andrews, Pebble Beach, Augusta National, Pinehurst and Winged Foot Rooms, which are also in the Savannah Inn.

The Registration Desk will be open for registration of MAG members and their guests on Sunday, May 4, from 11:00 a.m. to 5:00 p.m.; Monday, May 5, from 8:00 a.m. to 5:00 p.m.; Tuesday, May 6, from 8:00 a.m. to 5:00 p.m.; and Wednesday, May 7, from 8:00 a.m. to 12:00 noon.

MAG members and guests are requested to register at the MAG Registration Desk immediately on arrival at the Savannah Inn to obtain badges and programs. No one will be admitted to the Exhibit Hall, Meeting Room or other MAG functions without MAG Official registration badges.

MAG Scientific Sessions

MAG Scientific Sections will convene Monday afternoon, May 5, from 2:00 p.m. to 5:00 p.m., and Tues-

day afternoon, May 6, from 2:00 p.m. to 5:00 p.m., in Ballroom B and C.

MAG General Sessions Ballroom B and C

The Association will convene its first General Session for all MAG members on Sunday afternoon, May 4, at 1:00 p.m. at which time nominations for MAG offices will be made.

The second General Session will be held jointly with the MAG House of Delegates meeting on Monday morning, May 5, from 9:00 a.m. to 10:30 a.m. During this session the MAG President-Elect will outline his program for 1969-70.

A featured speaker on a General Assembly program at 12:00 noon on Monday, May 5, in Ballroom B and C, in addition to the GaMPAC Program, will be our special guest, Dwight Wilbur, M.D., President of the American Medical Association.

The third and final General Session will convene jointly with the MAG House of Delegates final meeting on Wednesday morning from 9:00 a.m. to 12:00 noon. At this last Session, MAG awards will be presented, election results announced and new officers installed, and the entire 115th Annual Session will be adjourned.

MAG House of Delegates Sessions Ballroom B and C

The first session of the House of Delegates will meet Monday morning, May 5, from 9:00 a.m. to 10:30 a.m. At this Session all reports and resolutions will be introduced to the House for referral to House Reference Committees.

All Reference Committees of the House will meet concurrently on Tuesday morning, May 6, in the St. Andrews, Pebble Beach, Augusta National, Pinehurst and Winged Foot Rooms from 9:00 a.m. until approximately 12:00 noon. Delegates and all MAG members are urged to attend these Reference Committee meetings so that they may make their views known to assist these Committees in their deliberations on those items of business before the Association House of Delegates. The second and final session of the MAG House of

Delegates will convene Wednesday morning, May 7, from 9:00 a.m. to 12:00 noon. At this session, the House Reference Committees will report their recommendations and the House will vote on these items of business which set MAG policy for 1969-70. Both sessions of the House will be held jointly with the MAG General Sessions to facilitate the overall business of the Association.

Delegates Registration Desk

Delegates are urged to attend both sessions of the House to fulfill their responsibility to the County Medical Society which they represent. Registration of MAG Delegates will be conducted at a SPECIAL DELEGATES REGISTRATION DESK in the Exhibit Area Entrance so that attendance and voting privileges may be checked by the House Credentials Committee. During this Delegates Registration, special badges will be given Delegates. As both sessions of the House will be held jointly with MAG General Sessions, special seating areas will be reserved for Delegates and their special badges will admit them to this separate section of the meeting room.

MAG Message Center

A message center will be maintained near the MAG Official Registration Desk for the convenience of the membership. Pages from the Woman's Auxiliary to MAG will staff this center during the entire session for incoming messages only.

An Official Bulletin Board at this message center will be available for notices of special importance during the Annual Session.

MAG Headquarters Office and Press Room

The Association Headquarters Office Staff will maintain a Headquarters Office in the Seminole Room on the first floor of the Savannah Inn for the conduct of Association business during the meeting.

An MAG Press Room will also be available for newspaper, radio and TV personnel during the entire meeting. This room is on the first floor of the Savannah Inn, in the Game Room on Factors Walk.

MAG Memorial Service

The Medical Association of Georgia will hold its traditional annual Memorial Service at the third Joint General Session on Wednesday morning, May 7, at 9:00 a.m. in the Ballroom B and C. All members and their guests are invited to attend this service which is held in memory of those members who died during the past Association year. The event will honor and recall the service and contributions of the following medical practitioners:

Wayne S. Aiken, Atlanta, October 2, 1968
C. H. Allen, Bremen, September 18, 1968
E. A. Allen, Atlanta, December 7, 1968
J. F. Arthur, Columbia, South Carolina, May 10, 1968
R. M. Avery, LaGrange, February 8, 1969
R. A. Bartholomew, Atlanta, January 7, 1969
L. S. Boyette, Ellaville, January 29, 1969
Stephen T. Brown, Atlanta, January 2, 1969
Warren F. Brown, Atlanta, February 19, 1969
Eleanor E. J. Bundy, Decatur, February 17, 1969
J. A. Combs, Decatur, November 13, 1968
Ernest Corn, Macon, August 26, 1968

Robert Crichton, Augusta, May 4, 1968
Edgar F. Fincher, Atlanta, January 12, 1969
W. W. Hillis, Sardis, October 19, 1968
John S. Howkins, Savannah, December 19, 1968
Harry Hutchins, Buford, February 1, 1969
H. B. Jenkins, Donalsonville, October 25, 1968
W. A. Johnson, Elberton, May 2, 1968
Harry C. King, Griffin, December 31, 1968
Seth E. Latham, Atlanta, July 18, 1968
John Looper, Dalton, February 4, 1969
L. F. Lovett, Statesboro, February 16, 1969
J. Calhoun McDougall, Atlanta, June 26, 1968
F. T. McElreath, Jr., Tennille, April 4, 1968
V. H. McMichael, Macon, November 12, 1968
M. R. McWhorter, Columbus, December 1, 1968
H. W. Muecke, Waycross, October 26, 1968
J. C. O'Neill, Savannah, November 23, 1968
Hollis E. Puckett, Savannah, May 4, 1968
Herbert F. Readling, Thomasville, November 11, 1968
H. Y. Righton, Savannah, November 12, 1968
Paul T. Russell, Albany, December 26, 1968
H. C. Schenck, Atlanta, October 13, 1968
Charles R. Smith, Columbus, September 2, 1968
Henry C. Standard, Decatur, July 25, 1968
Henry J. Tanner, Forest Park, June 10, 1968
William Tanner, Young Harris, February 2, 1969
J. Lowell Thomas, Rincon, September 11, 1968
C. D. Whelchel, Gainesville, July 25, 1968

Specialty Society and Alumni Meetings, Luncheons, and Dinners

Specialty Societies have planned business meetings, luncheons, and dinners for the membership of their organizations, and scientific meetings to which all physicians are invited, to be held in conjunction with the MAG Annual Session. These events are listed in the Official MAG Program, in the order of the date and time the event is scheduled—under Specialty Society Events.

Host Society Cocktail Party

Our host Society, the Georgia Medical Society, invites the membership and their wives to be their guests for cocktails on Tuesday evening, May 6, from 6:30 p.m. to 7:30 p.m., Swimming Pool area at the Savannah Inn, preceding the Annual Banquet. The Savannah Sugar Refining Corporation will sponsor this cocktail party.

Annual Banquet

The Medical Association of Georgia will honor its President at the traditional MAG Annual Banquet to be held Tuesday evening, May 6, immediately following the Georgia Medical Society Social Hour. The MAG Annual Banquet will be a seated dinner with entertainment starting at 8:00 p.m. in the Ballroom B and C of the Savannah Inn. *As space for this banquet is limited, members are urged to purchase their banquet tickets on Sunday, May 5—at the MAG Registration Desk.* Accordingly, Banquet Tickets will be sold on a "first come-first served" basis. Admission will be by ticket only. Tickets will be distributed to the Exhibitors prior to the Social Hour.

"A Costumed Cavalcade of Broadway's Greatest Musical Hits"—that's the description of the special entertainment which will highlight this year's Annual Banquet, Tuesday, May 5. The dazzling costumes and beautiful music of Doraine and Ellis are strictly for the family and will be but one of the delights of an evening of charm and festivity to be found at this year's big event, the Annual Banquet.

MAG Golf and Tennis Tournaments

The annual MAG golf tournament will be played on the magnificent Savannah Inn and Country Club course (18 holes, 72-par championship layout) featuring contoured fairways, raised greens—also 10 water holes. From the championship tees, the course measures 7,100 yards, but the tournament will be played from the white tees. The dates of the tournament will be Sunday and Monday, May 4 and 5. If you have a foursome already made up, be sure to inform the club pro, Mr. Jim Ferree, who will direct the tournament. If you do not, Mr. Ferree will place you with a foursome. Players will take care of their own green and cart fees. The Callaway handicapping system will prevail. Prizes will be awarded at the Annual Banquet, Tuesday, May 6. If you plan to enter the tournament, be sure to sign up as soon as you arrive at the meeting.

The first MAG tennis tournament will be a round-robin affair, played on the all-weather courts of the Savannah Inn and Country Club. Since this is something new for MAG meetings, it will greatly facilitate matters, if you wish to compete, if you so advise the tournament chairman, Dr. R. L. Schley, Savannah.

Medical Mile

What more fitting group than physicians should promote good physical fitness and conditioning among their own kind. As a special attraction to those members who are regular joggers, or those who just want to "keep up with their classmates," MAG has scheduled the first Annual Medical Mile Race, open to all who wish to compete for the winners' trophies or just obtain an "I Finished" button. Prizes will be awarded in two classifications: those under 45 years of age and those over 45. The race is scheduled to begin at 5:30 p.m., Monday, May 5, with the spectators' area open at 5:00 p.m. with choice of beverages served, courtesy of the local milers. Starting and finishing lines will be in front of the Pro Shop, Savannah Inn and Country Club.

County Society Officers Conference

A program of special interest to County Society Presidents and Secretaries is scheduled for 11:30 a.m., Tuesday, May 6. This session, which has the special sponsorship of the Public Service Committee, is being held during the Annual meeting in lieu of the usual February Conference, in order to reach a greater number of county society leaders. Especially successful programs from Georgia's own societies will be presented, and a special feature will be a Committee-sponsored luncheon with a special guest speaker who will be announced at a later date. County Medical Society Presidents and Secretaries will be guests of MAG at the luncheon, and others interested may purchase tickets in the Registration Area.

Scientific Exhibits

Scientific Exhibits will be displayed adjacent to Commercial Exhibits in the Wilmington Room of the Savannah Inn. The Scientific Exhibits are prepared by physicians who will be at their exhibits to discuss their presentation with the membership. All physicians are urged to visit each Scientific Exhibit in the interest of professional education. Awards for outstanding Scientific Exhibits will be presented at the Annual Banquet on Tuesday evening, in the Ballroom.

Commercial Exhibits

Approximately 50 Commercial Exhibits will be displayed in Ballroom A adjacent to the Main Meeting Room (Ballroom B and C). The exhibit Hall will be used to gain both entrance and exit to the Main Meeting Room. These exhibits will provide technical information of importance on products and services available to the medical profession.

It is extremely important that every member visit each of these exhibits and register with the exhibitor. Your cooperation is requested in that these displays are designed specifically to benefit the profession. Commercial Exhibitors play an extremely important role in making the MAG Annual Session possible through their support of the meeting. Your MAG Commercial Exhibit Committee asks that physicians be sure to visit and register at all Commercial Exhibit Booths.

The following firms have contributed funds to the Association for direct use in programming scientific speakers at this Annual Session: Eli Lilly and Company, Indianapolis, Indiana; Smith Kline and French, Philadelphia, Pennsylvania; Roche Laboratories, Nutley, New Jersey; and Geigy Pharmaceuticals, Ardsley, New York.

A list of Commercial Exhibitors already participating at this time in the MAG 115th Session is as follows:

Booth No.	Name of Firm
1	Parke, Davis & Company, Detroit, Michigan
2	Sandoz Pharmaceuticals, Hanover, New Jersey
4	Loma Linda Foods, Riverside, California
5	Upjohn Company, Kalamazoo, Michigan
6	Lakeside Laboratories, Inc., Milwaukee, Wisconsin
7	Marion Laboratories, Inc., Kansas City, Missouri
9	Coca-Cola Company, Atlanta, Georgia
10	IBM Corporation, Savannah, Georgia
11	A. H. Robins Company, Richmond, Virginia
12	William P. Poythress and Co., Inc., Richmond, Virginia
13	Ortho Pharmaceutical Corp., Raritan, New Jersey
20	American Medical Building Guild, Madison, Wisconsin
21	Astra Pharmaceutical Products, Inc., Worcester, Massachusetts
22	Marshall Erdman & Associates, Inc., Princeton, New Jersey
25	Pfizer Laboratories, Chamblee, Georgia
29	Siemens Medical of America, Inc., Addison, Illinois
30	Citizens and Southern National Bank, Atlanta, Georgia
31	Smith, Miller & Patch, Inc., New York, New York
32	Wachtel's Physician Supply Co., Savannah, Georgia
33	S. J. Tutag & Co., Detroit, Michigan
34	Mead Johnson Laboratories, Evansville, Indiana
38	Warren-Teed Pharmaceuticals, Inc., Columbus, Ohio
40	Stansell's Oxygen Service, Atlanta, Georgia
42	Life Insurance Company of Georgia, Atlanta
43	Stuart Division, Atlas Chemical, Pasadena, California
47	CIBA Pharmaceutical Co., Summit, New Jersey

Contributors of Money Only

Eli Lilly and Company, Indianapolis, Indiana
Hoffman and LaRoche, Inc., Nutley, New Jersey
Smith Kline and French Laboratories, Philadelphia, Pennsylvania
Geigy Pharmaceuticals, Ardsley, New York

Fifty Year Members

Physicians who have practiced medicine for 50 years will be honored at the MAG Annual Session by the award of a 50-year Pin and Certificate. These awards will be presented at the Annual Banquet on Tuesday

evening, May 6, at 8:00 p.m. in the Ballroom B and C. The following list contains the names of the members of the Medical Association who, as of the year 1969, have practiced medicine for 50 years. It does not record the names of physicians who have already received gold membership cards. This includes only those members in the class of 1919 who were also licensed in Georgia in 1919 as follows:

William Edward Campbell, Jr.	Atlanta
Robert Drane	Savannah
M. A. Ehrlich	Bainbridge
Robert C. Goolsby, Jr.	Macon
Walter R. Holmes	Atlanta
William Perrin Nicholson, Jr.	Atlanta
A. A. Rogers, Sr.	Commerce
Robert L. Rogers	Gainesville
Albert F. Saunders	Valdosta
David C. Williams	Macon

MAG Voting Privileges

The MAG Constitution and Bylaws state that dues for Association members shall be payable on or before January 1 of the year for which they are levied. The Bylaws further state that any member whose name has not been reported for enrollment and whose dues for

the current year have not been remitted to the MAG Headquarters Office on or before April 1 shall stand suspended until his name is properly reported and his dues for the current year properly remitted. The Secretary of each component county medical society must forward the physician's dues to MAG as the Association cannot under any circumstances receive such dues money directly from the member.

For voting purposes in the election of MAG officers at the Association Annual Session, only dues-paying members and certain other categories of membership will be allowed the privilege of voting. *If a member's MAG dues have not been forwarded to MAG prior to the time of an Annual Session, such member will not be allowed to vote unless that member pays his MAG dues to the County Society Secretary and the County Society Secretary gives such dues to the MAG Secretary during an Annual Session, but prior to the time of the official closing of the MAG Ballot Box, according to an MAG Council ruling.* If such procedure is followed, the MAG Secretary, on receipt of a physician's MAG dues from the physician's County Medical Society Secretary, will then authorize the Teller's Committee to provide the physician with a ballot for voting purposes.

VOTING RULES

Bylaws, Chapter V, Election of Officers

BYLAWS, CHAPTER V, ELECTION OF OFFICERS, SECTION 3. METHOD. The President shall appoint a committee of not less than three Tellers immediately after the close of nominations, who shall have charge of the election. The Secretary shall have prepared in advance an official ballot and an official ballot box, which shall be kept in the custody of the Tellers Committee. One ballot only shall be given to each active voting member when he presents himself to cast his ballot. Each

member and no other shall prepare his ballot and shall deposit it at that time in the locked ballot box.

The candidates for office receiving a majority of the votes shall be declared elected, but if no majority is received on the first ballot, the members present shall select by secret ballot the officer from the two candidates having the highest number of votes.

SECTION 4. TIME. Voting shall take place during the Annual Session at times set by the Council.

Voting hours for the 1969 Annual Session, as determined by Council, are as follows: May 4—2:30 to 5:00 p.m., May 5—8:00 a.m. to 6:00 p.m. and May 6—8:00 a.m. to 6:00 p.m.

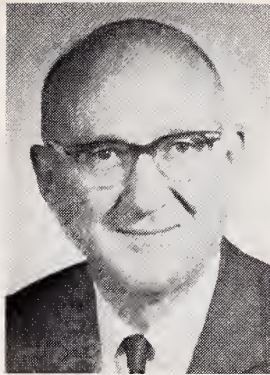
CALL FOR SCIENTIFIC EXHIBITS

115TH ANNUAL SESSION OF THE MEDICAL ASSOCIATION OF GEORGIA

Savannah, Georgia, May 4-7, 1969

For Information and Applications, Write:

John McClure, Jr., M.D., Chairman, MAG Scientific Exhibits Committee
938 Peachtree Street, N.E. • Atlanta, Georgia 30309



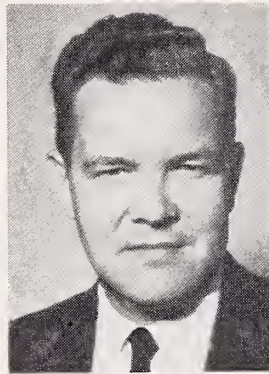
Charles R. Andrews
President



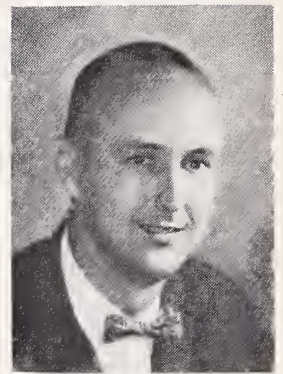
John Kirk Train
President-Elect



Fleming L. Jolley
First Vice President



John Rhodes Haverty
Secretary



Ronald F. Galloway
Second Vice President

OFFICERS AND COUNCIL OF THE MEDICAL ASSOCIATION OF GEORGIA

OFFICERS

President—Charles R. Andrews, Jr., Canton (1969)*
President-Elect—John Kirk Train, Savannah (1969)*
Immediate Past President—John T. Mauldin, Atlanta (1971)*
Past President—Walter E. Brown, Savannah (1970)
Past President—George H. Alexander, Forsyth (1969)
First Vice President—Fleming L. Jolley, Atlanta (1969)*
Second Vice President—Ronald F. Galloway, Augusta (1969)*
Chairman of Council—F. G. Eldridge, Valdosta (1969)*
Secretary—J. Rhodes Haverty, Atlanta (1969)*
Treasurer—John S. Atwater, Atlanta (1969)
Speaker of the House—Harrison L. Rogers, Atlanta (1971)*
Vice Speaker of the House—Preston D. Ellington, Augusta (1971)
Editor, JMAG—Edgar Woody, Jr., Atlanta (1969)

COUNCILORS

District:

- 1—C. E. Bohler, Brooklet (1970)*
- 2—J. D. Bateman, Albany (1970)
- 3—J. T. Christmas, Vienna (1970)
- 6—Ernest E. Proctor, Newnan (1971)
- 7—David A. Wells, Dalton (1971)
- 8—F. G. Eldridge, Valdosta (1971)
- 9—P. T. Scoggins, Commerce (1969)
- 10—William Rawlings, Sandersville (1969)

Bibb County Medical Society
 Braswell E. Collins, Macon (1969)
 Cobb County Medical Society
 W. C. Mitchell, Smyrna (1969)
 DeKalb County Medical Society
 Floyd R. Sanders, Decatur (1969)
 Fulton County Medical Society
 John T. Godwin, Atlanta (1971)
 J. Harold Harrison, Atlanta (1970)
 Fleming L. Jolley, Atlanta (1969)
 Georgia Medical Society
 Lee Howard, Jr., Savannah (1970)

Muscogee County Medical Society
 Roy L. Gibson, Columbus (1971)
 Richmond County Medical Society
 Harry D. Pinson, Augusta (1969)

VICE COUNCILORS

District:

- 1—L. H. Griffin, Claxton (1970)
- 2—R. A. Malone, Thomasville (1970)
- 3—John H. Robinson, Americus (1970)
- 6—Norman P. Gardner, Thomaston (1971)
- 7—Don Schmidt, Cedartown (1971)
- 8—Robert E. Perry, Jr., Brunswick (1971)
- 9—Robert S. Tether, Gainesville (1969)
- 10—M. A. Hubert, Athens (1969)

Bibb County Medical Society
 W. H. M. Weaver, Macon (1969)
 Cobb County Medical Society
 Remer Y. Clark, Jr., Marietta (1969)
 DeKalb County Medical Society
 M. Freeman Simmons, Decatur (1969)
 Fulton County Medical Society
 J. Norman Berry, Sandy Springs (1971)
 W. W. Moore, Jr., Atlanta (1970)
 T. J. Anderson, Jr., Atlanta (1969)
 Georgia Medical Society
 W. W. Osborne, Savannah (1970)
 Muscogee County Medical Society
 Louis A. Hazouri, Columbus (1971)
 Richmond County Medical Society
 J. L. Mulherin, Augusta (1969)

DELEGATES TO AMA AS OF JANUARY 1, 1969

<i>Delegate</i>	<i>Term Ending</i>
J. W. Chambers, LaGrange	(12-31-69)
John S. Atwater, Atlanta	(12-31-69)
J. Frank Walker, Atlanta	(12-31-70)
P. D. Ellington, Augusta	(12-31-70)
<i>Alternate</i>	<i>Term Ending</i>
Neal F. Yeomans, Waycross	(12-31-69)
H. S. Jennings, Gainesville	(12-31-69)
J. D. Bateman, Albany	(12-31-70)
F. W. Dowda, Atlanta	(12-31-70)

* Executive Committee

MAG 1969 Savannah Annual Session

LOCAL ARRANGEMENTS COMMITTEE FOR 1969 MAG ANNUAL SESSION

CHAIRMAN

Lee Howard, Jr., M.D.

PUBLICITY

Irving Victor, M.D.

SOCIAL HOUR AND BANQUET

John Zirkle, M.D.

TENNIS

R. L. Schley, M.D.

HOSPITALITY

W. W. Osborne, M.D.

GOLF

J. J. Holloman, M.D.

AUXILIARY

Mrs. John Kirk Train
Mrs. Walter Brown

Specialty Society Scientific Section Meeting Program Chairmen

ANESTHESIOLOGY

GEORGIA SOCIETY OF
ANESTHESIOLOGISTS
George J. Pastorius, M.D.
215 McLaws St.
Savannah

CHEST

GEORGIA CHAPTER, AMERICAN
COLLEGE OF CHEST PHYSICIANS &
GEORGIA THORACIC SOCIETY &
GEORGIA TB ASSOCIATION
James Alexander, M.D.
40 Medical Arts Center
Savannah

DERMATOLOGY

GEORGIA SOCIETY OF
DERMATOLOGISTS
Vincent J. Cirincione, M.D.
46 Medical Arts Center
Savannah

DIABETES

GEORGIA DIABETES ASSOCIATION
Jules Victor, Jr., M.D.
5 Medical Arts Center
Savannah

GENERAL PRACTICE

GEORGIA ACADEMY OF
GENERAL PRACTICE
Harold Smith, M.D.
3 Medical Arts Center
Savannah

MEDICINE

GEORGIA SOCIETY OF
INTERNAL MEDICINE
Jules Victor, Jr., M.D.
5 Medical Arts Center
Savannah

GEORGIA CHAPTER, AMERICAN COLLEGE OF PHYSICIANS

Lawrence Lee, M.D.
2420 Abercorn Street
Savannah

NEUROSURGERY

GEORGIA NEUROSURGICAL
SOCIETY
Upton Clary, M.D.
22 Medical Arts Center
Savannah

OBSTETRICS AND GYNECOLOGY

GEORGIA STATE OBSTETRICAL &
GYNECOLOGICAL SOCIETY
William E. Josey, M.D.
69 Butler Street, S.E.
Atlanta

OPHTHALMOLOGY AND OTOLARYNGOLOGY

GEORGIA SOCIETY OF
OPHTHALMOLOGY &
OTOLARYNGOLOGY
John C. Howard, M.D.
317 E. Hall Street
Savannah

Franklin P. Bousquet, Jr., M.D.
P.O. Box 1008
Savannah

PATHOLOGY

GEORGIA ASSOCIATION OF
PATHOLOGISTS
Robert M. Howard, M.D.
P.O. Box 3036
Savannah

PEDIATRICS

GEORGIA CHAPTER, AMERICAN
ACADEMY OF PEDIATRICS
Milton Mazo, M.D.
4 Medical Arts Center
Savannah

PSYCHIATRY

GEORGIA PSYCHIATRIC
ASSOCIATION
Raymond Sowell, M.D.
2203 Abercorn Street
Savannah

PUBLIC HEALTH

GEORGIA CHAPTER, AMERICAN
ASSOCIATION OF PUBLIC HEALTH
PHYSICIANS
W. D. Lundquist, M.D.
P.O. Box 6148
Savannah

RADIOLOGY

GEORGIA RADIOLOGICAL SOCIETY
John B. Rabun, M.D.
311 E. Hall Street
Savannah

SURGERY

GEORGIA CHAPTER, AMERICAN
COLLEGE OF SURGEONS
Tom Freeman, M.D.
200 E. 31st Street
Savannah

ORTHOPEDICS

GEORGIA ORTHOPEDIC SOCIETY
C. W. Rawson, Jr., M.D.
8 Medical Arts Center
Savannah

THE PROGRAM

SATURDAY, MAY 3

SPECIALTY SOCIETY EVENTS

NOTE: Make reservations in advance with Chairman.

9:00 Georgia Society of Anesthesiologists Executive Council Meeting
St. Andrews Room, Savannah Inn
PRESIDING
Frederick A. Carpenter, M.D., Atlanta, President

9:00 Georgia Chapter, American College of Chest Physicians, Georgia Thoracic Society and Georgia TB Association Scientific Meeting
DeSoto Hilton Hotel
James Alexander, M.D., Savannah, Chairman
MODERATOR
Lois Ellison, M.D., Augusta

9:10 Pathophysiology of Acute Respiratory Failure
Giles F. Filley, M.D., Denver, Colorado

10:00 Break

10:15 Acid-Base and Blood Gas Problems
D. Boyd Bigelow, M.D., Denver, Colorado

11:00 Respiratory Failure in Chronic Airway Obstruction
Giles F. Filley, M.D., Denver, Colorado

12:00 Questions and Discussion

12:30 Luncheon and Joint Business Meeting Georgia Thoracic Society and Georgia Chapter, American College of Chest Physicians
DeSoto Hilton Hotel

2:00 MODERATOR
Ross L. McLean, M.D., Atlanta

2:00 Pediatric Problems in Respiratory Care
Frank Anderson, M.D., Augusta

2:45 Respiratory Care Problems in the Surgical Patient
Robert Ellison, M.D., Augusta

3:30 Break

3:45 Intensive Respiratory Care Unit: Organization, Responsibilities and Functions
D. Boyd Bigelow, M.D., Denver, Colorado

4:30 Questions and Discussion

12:30 Georgia Chapter, American Academy of Pediatrics, Howard J. Morrison Memorial Session, Luncheon and Business Meeting
Winged Foot Room, Savannah Inn
Milton Mazo, M.D., Savannah, Chairman

1:00 Georgia Society of Anesthesiologists Scientific and Business Meeting
(All Physicians Invited)
Pebble Beach Room, Savannah Inn
George J. Pastorius, M.D., Savannah, Chairman

PRESIDING
Fred A. Carpenter, M.D., Atlanta, President

1:00 The Pre-Operative Evaluation of Patients with Heart Disease
John H. Edmonds, Jr., M.D., Augusta

1:45 The Physiological Effect of Surgery Upon the Cardiovascular System
Thomas J. Yeh, M.D., Savannah

2:30 Break

3:00 Progress, Problems and Probabilities of Eliminating Flammable Anesthesia in This Decade
Robert A. Hingson, M.D., Pittsburgh, Pennsylvania

4:00 Business Meeting

7:00 Social Hour (Courtesy of Ayerst Laboratories)

2:30 Georgia Radiological Society Business Meeting
St. Andrews Room, Savannah Inn
John B. Rabun, M.D., Savannah, Chairman
PRESIDING
Harry H. McGee, Jr., M.D., Savannah

3:00 Georgia Association of Pathologists Business Meeting
Poolside Gazebo, Savannah Inn
Robert M. Howard, M.D., Savannah, Chairman

6:00 Georgia Chapter, American College of Chest Physicians, Georgia Thoracic Society and Georgia TB Association Social Hour
DeSoto Hilton Hotel
James Alexander, M.D., Savannah, Chairman

7:00 Georgia Society of Dermatologists Social Hour and Dinner
Emerald Room 1, Savannah Inn
Vincent J. Cirincione, M.D., Savannah, Chairman

7:00 Georgia Chapter, American Academy of Pediatrics, Howard J. Morrison Memorial Session, Society Hour
Wilmington Room, Savannah Inn
Milton Mazo, M.D., Savannah, Chairman

7:30 Georgia Radiological Society Social Hour and Dinner
Savannah Yacht Club
John B. Rabun, M.D., Savannah, Chairman

SUNDAY, MAY 4

SPECIALTY SOCIETY EVENTS

NOTE: Make reservations in advance with Chairman.

- 9:00 Georgia Society of Anesthesiologists Scientific Meeting
(All Physicians Invited)
Pinehurst Room, Savannah Inn
George Pastorius, M.D., Savannah, Chairman
PRESIDING
Frederick A. Carpenter, M.D., Atlanta, President
- 9:00 Cardiac Arrhythmias During and Following Surgery
John H. Edmonds, M.D., Augusta
- 9:45 Arterial Blood Gas Values: Clinical Application in Management of Acid-Base Imbalance
Thomas J. Yeh, M.D., Savannah
- 10:30 Break
- 11:00 Anesthesia and Medical Problems in the Developing Nations (16 mm color film with narration). Wives invited.
Robert A. Hingson, M.D., Pittsburgh, Pennsylvania
-
- 9:00 Georgia Society of Ophthalmology and Otolaryngology Scientific Meetings
(All Physicians Invited)
- 9:00 Ophthalmology
Augusta National Room, Savannah Inn
Franklin P. Bousquet, Jr., M.D., Savannah, Chairman
Some Complications of Intraocular Surgery: and the Differential Diagnosis of Elevated Lesions of the Posterior Pole
R. Robb McDonald, M.D., Philadelphia, Pennsylvania
- 9:00 Ear, Nose and Throat
St. Andrews Room, Savannah Inn
John C. Howard, M.D., Savannah, Chairman
Internal Maxillary Artery Ligation for Epistaxis
William Hudson, M.D., Durham, North Carolina

GENERAL PROGRAM

- 11:00 General and Delegates Registration
Exhibit Area Entrance, Savannah Inn
- 12:00 Visit Exhibits

SPECIALTY SOCIETY EVENTS

NOTE: Make reservations in advance with Chairman.

- 11:30 Georgia Orthopedic Society Luncheon
Winged Foot Room, Savannah Inn
C. W. Rawson, Jr., M.D., Savannah, Chairman
-
- 11:30 Georgia Neurosurgical Society Luncheon and Scientific Meeting
Pebble Beach Room, Savannah Inn
Upton Clary, M.D., Savannah, Luncheon Chairman
Marshall B. Allen, M.D., Augusta, Scientific Program Chairman
Dale Richardson, M.D., Atlanta, Secretary
-
- 11:30 Georgia Chapter, American Academy of Pediatrics, Howard J. Morrison Memorial Session, Luncheon
Emerald Room, Savannah Inn
Milton Mazo, M.D., Savannah, Chairman
-
- 11:30 Georgia Society of Dermatologists Luncheon
Peter Tondee Lounge, Savannah Inn
Vincent J. Cirincione, M.D., Savannah, Chairman
-
- 11:30 Georgia Society of Ophthalmology and Otolaryngology Luncheon
Emerald Room 1, Savannah Inn
John C. Howard, M.D., Savannah, Chairman
Franklin P. Bousquet, Jr., M.D., Savannah, Chairman
ADDRESS
John Kirk Train, M.D., Savannah, MAG President-Elect

SUNDAY, MAY 4

GENERAL PROGRAM

- 1:00 MAG General Session
(All MAG, Auxiliary Members and Guests Invited)
Ballroom, Savannah Inn
PRESIDING
Charles R. Andrews, M.D., Canton, President, Medical Association of Georgia
- Call to Order
- Invocation and Religious Observance
- Presentation of Colors
- National Anthem
- Welcome
John G. Zirkle, M.D., Savannah, President, Georgia Medical Society

Greetings

Honorable J. Curtis Lewis, Jr., Mayor
of Savannah

Introduction of Distinguished Guests Special Program on the "Exciting Story of Savannah's Restoration"

Nomination of Officers and Councilors (Announcement of Tellers Committee)

President-Elect

Second Vice President

Secretary (to serve until 1972)

Ninth District Councilor (to serve until
1972)

Ninth District Vice Councilor (to serve
until 1972)

Tenth District Councilor (to serve until
1972)

Tenth District Vice Councilor (to serve
until 1972)

Bibb County Medical Society Councilor
(to serve until 1972)

Bibb County Medical Society Vice Coun-
cilor (to serve until 1972)

Cobb County Medical Society Councilor
(to serve until 1972)

Cobb County Medical Society Vice Coun-
cilor (to serve until 1972)

DeKalb County Medical Society Councilor
(to serve until 1972)

DeKalb County Medical Society Vice
Councilor (to serve until 1972)

Fulton County Medical Society Councilor
(to serve until 1972)

Fulton County Medical Society Vice Coun-
cilor (to serve until 1972)

Richmond County Medical Society Coun-
cilor (to serve until 1972)

Richmond County Medical Society Vice
Councilor (to serve until 1972)

AMA Delegate (term beginning January 1,
1970 and expiring December 31, 1971)
(For office held by J. W. Chambers,
M.D.)

AMA Alternate Delegate (term beginning
January 1, 1970 and expiring Decem-
ber 31, 1971) (For office held by Neal
F. Yeomans, M.D.)

AMA Delegate (term beginning January
1, 1970 and expiring December 31,
1971) (For office held by John S. At-
water, M.D.)

AMA Alternate Delegate (term beginning
January 1, 1970 and expiring December
31, 1971) (For office held by Henry S.
Jennings, M.D.)

Nomination for General Practitioner of the Year Award

(To be voted on by House of Delegates)

2:30 Visit Exhibits

SPECIALTY SOCIETY EVENTS

NOTE: Make reservations in advance with Chairman.

2:00 Georgia Society of Ophthalmology and Oto-
laryngology Scientific Meetings
(All Physicians Invited)

2:00 Ophthalmology

Augusta National Room, Savannah Inn

Franklin P. Bousquet, Jr., M.D., Savannah,
Chairman

2:00 Summary and Round Table Discussion

R. Robb McDonald, M.D., Philadelphia,
Pennsylvania

2:45 Scientific Papers (Ophthalmology)

RESIDENTS:

Emory University Clinic:

George D. Presley, M.D.

Grady Hospital:

Barry N. Hymann, M.D.

William H. Jarratt, M.D.

John A. Wells, Jr., M.D.

Talmadge Memorial Hospital:

C. George DeBelly, M.D.

Joe L. McLendon, M.D.

John S. Newton, M.D.

Richard Nutt, M.D.

Silas C. Read, M.D.

S. Allen Stocks, M.D.

2:00 Ear, Nose and Throat

St. Andrews Room, Savannah Inn

John C. Howard, M.D., Savannah, Chairman

2:00 Preoperative Radiation in Carcinoma of the
Laryngopharynx

William Hudson, M.D., Durham, North
Carolina

3:00 The Management of Post-Traumatic Cerebro-
spinal Fluid Rhinorrhea

William Hudson, M.D., Durham, North
Carolina

2:30 Georgia Radiological Society Scientific Meeting
(All Physicians Invited)

Ballroom, Savannah Inn

John B. Rabun, M.D., Savannah, Chairman

PRESIDING

Harry H. McGee, Jr., M.D., Savannah, Presi-
dent

2:30 Some Observations Regarding Angiographic
Findings in Pulmonary Emboli

Wade H. Shuford, M.D., Atlanta

2:45 Radiologist Interprets Chest Signs and Sym-
ptoms

George J. Baylin, M.D., Durham, North
Carolina

3:15 Vena Cavography

Rex Teeslink, M.D., Augusta

3:30 May I See Your Hands, Please?—A Session
on X-Ray Manifestations of Changes in the
Hands in Different Diseases

George J. Baylin, M.D., Durham, North
Carolina

4:10 Film Panel

James V. Rogers, Jr., M.D., Atlanta

- 3:00 Georgia Orthopedic Society Scientific Meeting
(All Physicians Invited)
Pinehurst Room, Savannah Inn
C. W. Rawson, Jr., M.D., Savannah, Chairman
PRESIDING
C. W. Rawson, Jr., M.D., Savannah
- 3:10 Recognition and Treatment of Kyphotic Deformities of the Spine in Children
Charles I. Hancock, M.D., and William C. Collins, M.D., Decatur
- 3:30 Current Management of Carpal Tunnel Syndrome
James L. Becton, M.D., Augusta
- 3:50 Fracture-Dislocations of the Ankle
George Hunter, M.D., Columbus
- 4:15 (To be announced)
James W. Harkess, M.D., Louisville, Kentucky
- 4:35 Pulmonary Embolism
Thomas Yeh, M.D., Savannah
-
- 3:00 Georgia Neurosurgical Society Business Meeting
Pebble Beach Room, Savannah Inn
Upton Clary, M.D., Savannah, Chairman
-
- 2:30 Georgia Chapter, American Academy of Pediatrics, Howard J. Morrison Memorial Session, Scientific Meeting
(All Physicians Invited)
Winged Foot Room, Savannah Inn
Milton Mazo, M.D., Savannah, Chairman
PRESIDING
Joseph H. Patterson, M.D., Atlanta
- 2:30 Jaundice in the Newborn Infant—Prevention and Treatment
Jerrold F. Lucey, M.D., Burlington, Vermont
- 3:15 Diagnosis and Treatment of the Distressed Newborn
Thomas K. Oliver, M.D., Seattle, Washington
- 4:00 Break
- 4:10 Panel Discussion on Problems of the Newborn
MODERATOR
Joseph H. Patterson, M.D., Atlanta
PANELISTS
Jerrold F. Lucey, M.D., Burlington, Vermont
Thomas K. Oliver, M.D., Seattle, Washington
Audrey K. Brown, M.D., Augusta
James R. Gray, M.D., Atlanta
-
- 3:00 Georgia Chapter, American Association of Public Health Physicians and Georgia Psychiatric Association Scientific Meeting
(All Physicians Invited)
Emerald Room 1, Savannah Inn
W. D. Lundquist, M.D., Savannah, Chairman
(Public Health)

Raymond Sowell, M.D., Savannah, Chairman
(Psychiatry)

PRESIDING

H. Karl Sessions, M.D., Atlanta

- 3:00 Mutual Assistance Between Psychiatry and Public Health
Harold L. McPheeters, M.D., Atlanta
-
- 3:00 Georgia Association of Pathologists and Georgia Society of Dermatologists Scientific Meeting
(All Physicians Invited)
Peter Tondee Lounge, Savannah Inn
Robert M. Howard, M.D., Savannah, Chairman
Vincent J. Cirincione, M.D., Savannah, Chairman
- 3:00 Dermatological Manifestations of Internal Disease—Clinical and Pathological Findings
Harold O. Perry, M.D., Rochester, Minnesota
- 3:30 Dermatological Manifestations of Systemic Disease
Andrew Ranier, M.D., Lake Charles, Louisiana
- 4:00 Lymphomatoid Papulosis
Robert M. Fine, M.D., Decatur, and Harold D. Meltzer, M.D., East Point
- 4:15 Newer Thoughts on Syphilis
Sidney Olansky, M.D., Atlanta

5:00 Visit Exhibits

5:30 Movie: Beyond Conception

Sponsored by Family Planning Department, Emory University School of Medicine

Augusta National Room, Savannah Inn

Robert Hatcher, M.D., Atlanta, Chairman

SPECIALTY SOCIETY EVENTS

NOTE: Make reservations in advance with Chairman.

- 7:00 Georgia Chapter, American College of Surgeons Banquet
Emerald Room 1, Savannah Inn
Thomas R. Freeman, M.D., Savannah, Chairman
-
- 7:00 Georgia State Obstetrical and Gynecological Society Social Hour and Dinner
Ballroom, Savannah Inn
William E. Josey, M.D., Atlanta, Chairman
-
- 7:30 Georgia Chapter, American Academy of Pediatrics Social Hour and Dinner
Peter Tondee Restaurant, Savannah Inn
Milton Mazo, M.D., Savannah, Chairman

MONDAY, MAY 5

SPECIALTY SOCIETY EVENTS

NOTE: Make reservations in advance with Chairman.

- 7:30 Georgia Diabetes Association Breakfast and Business Meeting
Winged Foot Room, Savannah Inn
Jules Victor, Jr., M.D., Savannah, Chairman

GENERAL PROGRAM

- 8:00 **Registration**
Exhibit Area Entrance, Savannah Inn
- 8:30 **Visit Exhibits**
- 9:00 **MAG General Session**
(All MAG, Auxiliary Members and Guests Invited)
Ballroom, Savannah Inn
PRESIDING
Charles R. Andrews, Jr., M.D., Canton, President, Medical Association of Georgia
Call to Order
Invocation
Our Association Future for 1969-70
John Kirk Train, M.D., Savannah, President-Elect, Medical Association of Georgia
Report of the Auxiliary
Mrs. S. William Clark, Jr., Waycross, President-Elect
A Report from the Student American Medical Association Chapter Presidents
Mr. A. Lucian Cousins, President, Medical College of Georgia Chapter
Mr. Cyle Ferguson, President, Emory University School of Medicine Chapter
- 10:30 **House of Delegates Meeting**
Harrison L. Rogers, M.D., Atlanta, Speaker of the House
Order of Business (See Delegates Handbook)
- MAG General Assembly**
(All MAG, Auxiliary Members and Guests Invited)
PRESIDING
Charles R. Andrews, Jr., M.D., Canton, President, Medical Association of Georgia
Reorganization and Objectives of the American Medical Association
Dwight L. Wilbur, M.D., President, American Medical Association
GaMPAC Speaker
(To be announced)

- 1:00 **Visit Exhibits**

2:00 General Scientific Meeting

(All Physicians Invited)
Ballroom, Savannah Inn
PRESIDING

J. L. Alexander, M.D., Savannah

Cardiac Transplant Symposium

2:00 Heart Transplant

Denton A. Cooley, M.D., Houston, Texas

2:30 Cardiologist Role in Heart Transplant

Robert D. Leachman, M.D., Houston, Texas

3:00 Immunologic Problems in Heart Transplant

John R. Montgomery, M.D., Houston, Texas

3:00 Moral Aspect of Cardiac Transplant

Reverend Paul B. McCleave, Chicago, Illinois

4:00 Panel Discussion

MODERATOR

J. L. Alexander, M.D., Savannah

PANELISTS

Denton A. Cooley, M.D., Houston, Texas

Robert D. Leachman, M.D., Houston, Texas

John R. Montgomery, M.D., Houston, Texas

Rev. Paul B. McCleave, Chicago, Illinois

2:00 Obstetrics and Gynecology Section Meeting

(All Physicians Invited)

Augusta National Room, Savannah Inn

PRESIDING

A. Cullen Richardson, M.D., Atlanta

2:00 Gynecologic Endocrinology

Melvin L. Taymor, M.D., Boston, Massachusetts

Robert B. Greenblatt, M.D., Augusta

3:00 Panel Discussion

3:30 Break

3:45 Progress Report

Maternal and Infant Care Welfare Division, Georgia Department of Public Health

SPECIALTY SOCIETY EVENTS

NOTE: Make reservations in advance with Chairman.

- 5:00 Georgia State Obstetrical and Gynecological Society Business Meeting
Augusta National Room, Savannah Inn
William E. Josey, M.D., Atlanta, Chairman

- 5:30 Medical Mile—MAG Athletic Event**
Start and Finish Line, Savannah Inn Pro Shop
 D. L. Brawner, M.D., Savannah, Chairman

ALUMNI EVENTS

NOTE: Make reservations in advance with Chairman.

- 6:30 Emory University School of Medicine Alumni Reception and Banquet
Emerald Room, Savannah Inn
 F. William Dowda, M.D., Atlanta, Chairman
- 6:30 Medical College of Georgia Alumni Reception and Banquet
Reception at Poolside and Banquet in Ballroom, Savannah Inn
 W. G. Sutlive, M.D., and J. C. Metts, Jr., M.D., Savannah, Co-Chairmen

TUESDAY, MAY 6

GENERAL PROGRAM

- 8:00 Registration**
Exhibit Area Entrance, Savannah Inn
- 8:30 Visit Exhibits**
- 9:00 Reference Committee Meetings**
Savannah Inn
 Reference Committee No. 1:
Pebble Beach Room
 Reference Committee No. 2:
St. Andrews Room
 Reference Committee No. 3:
Winged Foot Room
 Reference Committee No. 4:
Pinehurst Room
 Reference Committee No. 5:
Augusta National Room
- 11:30 County Medical Society Officers Program**
 (Presidents and Secretaries of County Societies Invited)
Emerald Room I, Savannah Inn
 PRESIDING
 Charles R. Andrews, Jr., M.D., President, Medical Association of Georgia
Medicine and Religion Activities in Cobb County
 Noah Meadows, M.D., Marietta, Cobb County Medical Society
A System of Coordinating Hospital Staff and County Medical Society Meetings
 William Huger, M.D., Atlanta, Fulton County Medical Society
Building Attendance at County Medical Meetings
 Joe S. Robinson, M.D., Macon, Bibb County Medical Society

- 12:30 County Medical Society Officers Luncheon**
 (Presidents and Secretaries of County Societies Invited)
Emerald Room, Savannah Inn
 PRESIDING
 Charles R. Andrews, Jr., M.D., President, Medical Association of Georgia

A County Society Is as Strong as Its Officers
 Speaker to be announced

SPECIALTY SOCIETY EVENTS

NOTE: Make reservations in advance with Chairman.

- 12:30 Georgia Academy of General Practice Luncheon and Business Meeting
Augusta National Room, Savannah Inn
 Harold Smith, M.D., Savannah, Chairman
- 12:30 Georgia Society of Internal Medicine and Georgia Chapter, American College of Physicians Luncheon
St. Andrews Room, Savannah Inn
 Jules Victor, Jr., M.D., Savannah, Chairman
 Lawrence Lee, M.D., Savannah, Chairman

- 2:00 General Scientific Meeting**
 (All Physicians Invited)
Ballroom, Savannah Inn
 PRESIDING
 T. R. Freeman, M.D., Savannah

Symposium on Automotive Safety

- 2:00 Safety's First Commitment Is Prevention**
 Mr. Howard Pyle, Chicago, Illinois
- 2:30 Highway Systems Research Car Data and Analysis**
 Mr. Fletcher Platt, Dearborn, Michigan
- 3:00 (To be announced)**
 Mr. Roy C. Haeusler, Detroit, Michigan
- 3:30 The Psychiatrist and Automotive Safety**
 Alfred A. Messer, M.D., Atlanta
- 4:00 Panel: Questions and Answers**
 MODERATOR
 T. R. Freeman, M.D., Savannah
 PANELISTS
 Mr. Howard Pyle, Chicago, Illinois
 Mr. Fletcher Platt, Dearborn, Michigan
 Mr. Roy C. Haeusler, Detroit, Michigan
 Alfred A. Messer, M.D., Atlanta
- 5:00 Visit Exhibits**
- 6:30 Georgia Medical Society Social Hour**
 (All MAG Members, Their Wives and Exhibitors Invited)

Sponsored by the Savannah Sugar Refining Corporation
Poolside, Savannah Inn

8:00 Annual Banquet
Ballroom, Savannah Inn

PRESIDING

Charles R. Andrews, Jr., M.D., Canton,
President, Medical Association of
Georgia

Presentation of Awards:

50 Year Certificates
Certificates of Appreciation
Scientific Exhibit Awards
Golf and Tennis Awards

**Installation of President of Medical
Association of Georgia
Entertainment**

WEDNESDAY, MAY 7

8:00 Registration
Exhibit Area Entrance, Savannah Inn

8:30 Visit Exhibits

9:00 MAG General Session
(All MAG and Auxiliary Members and
Guests Invited)

Ballroom, Savannah Inn

PRESIDING

Charles R. Andrews, Jr., M.D., Canton,
President, Medical Association of
Georgia

Memorial Service

**Presentation of General Practitioner of
the Year Award**

Irving Hellenga, M.D., Toccoa, Presi-
dent, Georgia Academy of General
Practice

Presentation of Civic Endeavor Award
President of Recipient's County Medi-
cal Society

Presentation of Hardman Award

John Kirk Train, M.D., Savannah,
President-Elect, Medical Association
of Georgia

**Presentation of Distinguished Service
Award**

Charles R. Andrews, Jr., M.D., Canton,
President, Medical Association of
Georgia

**Selection of Site for May 1972, 1973
and 1974 Annual Session**

**Announcement of MAG Election Re-
sults**

Chairman, Tellers Committee

Installation of 1969-70 Officers

**10:00 House of Delegates Second Meet-
ing**

PRESIDING

Harrison L. Rogers, M.D., Atlanta,
Speaker of the House

**Order of Business (See Delegates
Handbook)**

Adjournment of the House

Adjournment of 115th Annual Session

ANNUAL SESSION AT A GLANCE

- *A Scientific Session:* Two and a half days of papers and panels with something of interest for everyone.
- *A Technical and Scientific Exhibit:* We plan for nearly 60 exhibits featuring new procedures, equipment, pharmaceuticals, etc.
- *A Social Event:* Featuring luncheons, cocktail parties, banquets, and top flight nationally recognized entertainment; where old friends meet and share a good time together.
- *Alumni Get-Togethers:* Ties with the Alma Mater will be renewed as each one arranges its banquets and class reunions.
- *Sports Events:* This year for the first time we will

have a tennis tournament in addition to the traditional golf tournament; water skiing; charter cruises on the bay.

- *Art Show:* An art show is in the planning stages. This year, for the first time, we plan to exhibit works of art by the physicians of Georgia and members of their families. Get out your paint and brushes and cameras now.

- *For the Wives:* The Annual Meeting is not just for the physician alone. The physician's wife will enjoy the relaxation of the beautiful Savannah facilities and the attractive program arranged especially for her by the Auxiliary.

A total of 36 hours of AAGP Credit has been requested.

GENERAL ASSEMBLY SPEAKER

EDWARD J. GURNEY, U.S. Senator From Florida

12 noon

Monday, May 5, 1969

Ballroom

The Savannah Inn and Country Club

Guest Speakers



DWIGHT LOCKE WILBUR, M.D.

San Francisco, California

DWIGHT LOCKE WILBUR, M.D., President of the American Medical Association, will be the guest speaker at the General Assembly Monday, May 5 at 12 noon.

Dr. Wilbur received his medical degree in 1926 from the University of Pennsylvania and his M.S. in medicine from the University of Minnesota. He is known for his service as a practicing physician, teacher, editor and public servant. For six years he served as a consulting physician at the Mayo Clinic, and for the past 31 years he has been on the clinical faculty at Stanford's School of Medicine, where he has been Clinical Professor of Medicine since 1949.

A practicing physician for 40 years and an internist and gastroenterologist, Dr. Wilbur is Chief of Medical Service at French Hospital in San Francisco, and is on the staff of several other hospitals in the Bay area. He is chairman of the AMA Council on Health Manpower, and formerly served as commissioner and chairman of the AMA Commissioners to the Joint Commission on Accreditation of Hospitals. He was a member of the Board's study Committee on Planning and Development, and presently

is on the Advisory Committee to the Department of Health, Education and Welfare.

A past president of the California Academy of Medicine, American Gastroenterological Association and the American College of Physicians, Dr. Wilbur is also a member of the American Society for Clinical Investigation and the Association of American Physicians. He is a diplomate of the American Board of Internal Medicine and has also served as a member of the Subcommittee on Food and Nutrition of the National Research Council, and on a committee of the National Institute of Arthritis and Metabolic Diseases.

In 1963, Dr. Wilbur was elected to Mastership in the American College of Physicians. In 1966 he received the Julius Friedenwald Medal from the American Gastroenterological Association for outstanding achievement in the field. That same year, the Army presented him with the Outstanding Civilian Service Medal.

The topic of Dr. Wilbur's paper will be the "Reorganization and Objectives of the American Medical Association."

DENTON A. COOLEY, M.D.

Houston, Texas



DENTON A. COOLEY, M.D., Professor of Surgery at Baylor University College of Medicine, and Chief, Cardiovascular Surgery, at the Texas Heart Institute of St. Luke's Texas Children's Hospital will speak

before the General Scientific Meeting at 2:00 p.m. Monday, May 5.

Dr. Cooley received his M.D. degree from Johns Hopkins University in 1944, and completed his in-

ternship and residency in surgery there in 1950. From 1950-51 he was the Senior Surgical Registrar in thoracic surgery at the Brompton Hospital for Chest Diseases in London, England. In addition to his duties at Baylor University and St. Luke's Hospital, Dr. Cooley is Physician-in-Chief at the Texas Heart Institute, and attending surgeon and consultant in cardiovascular surgery at a number of other institutions.

Dr. Cooley has received numerous awards from

civic as well as medical organizations. In 1955 he was voted one of the Ten Outstanding Young Men in the United States by the U.S. Junior Chamber of Commerce; in 1967 he received the René Leriche Prize (for the most significant contribution to cardiovascular surgery) from the International Surgical Society, and in 1968 he received the Distinguished Achievement Award from Modern Medicine.

The subject of Dr. Cooley's presentation will be "Cardiac Transplantation."



ROBERT D. LEACHMAN, M.D.

Houston, Texas

ROBERT DeWITT LEACHMAN, M.D. of Houston, Texas, will speak before the first General Scientific Meeting on Monday, May 5 at 2:30 p.m.

Dr. Leachman received his M.D. degree with honor from Baylor University College of Medicine in 1954. He served his internship and his residency in internal medicine at Jefferson Davis Hospital in Houston. His postgraduate work included a fellow-

ship in infectious diseases at Baylor, and a fellowship in pediatric cardiology at Texas Children's Hospital. Dr. Leachman is a diplomate of the American Board of Internal Medicine and of the American Board of Cardiology. His practice is limited to heart diseases.

Dr. Leachman will speak on the "Cardiologist's Role in Heart Transplantation."

THE REV. DR. PAUL B. McCLEAVE

Chicago, Illinois



THE REV. DR. PAUL B. McCLEAVE is Director of the Department of Medicine and Religion of the American Medical Association. He received his B.D. degree from Presbyterian Theological Seminary in Omaha, a graduate diploma from the University of Geneva in Switzerland, and an honorary Doctor of Laws degree from the University of Tulsa in Oklahoma.

During World War II, Dr. McCleave served as a chaplain in the United States Navy and spent 27 months in the South Pacific. In 1947 he became

president of the College of Emporia in Kansas, and from 1952-61 he held a post in a Presbyterian church in Bozeman, Montana, before joining the AMA.

Dr. McCleave has appeared on national television on such programs as Art Linkletter's House Party, the Today Show, Contact, and numerous local television and radio shows.

The topic of Dr. McCleave's paper is the "Moral and Ethical Aspects of Cardiac Transplants," and it will be presented at 3:30 p.m., May 5, during the General Scientific Meeting.



MELVIN L. TAYMOR, M.D.

Boston, Massachusetts

MELVIN L. TAYMOR, M.D., Assistant Clinical Professor of Gynecology at Harvard Medical School and Associate in Surgery (GYN) at the Peter Bent Brigham Hospital in Boston, will speak at 2:00 p.m. on Monday, May 5 before the Obstetrics and Gynecology Section Meeting.

An abstract of his paper, "Advances in Gonadotropin Research," follows:

Recent progress in techniques in gonadotropin assay have paved the way for increased understanding of cyclic hormonal changes involved in reproductive physiology and has placed therapeutic regimens on a sounder physiologic basis. Radio-immune assays for FSH and LH performed simultaneously during the normal menstrual cycle have

revealed that FSH levels are relatively high early in the follicular phase and decline prior to the mid mid-cycle rise of LH. This information has been of value in planning gonadotropin therapy. Furthermore, the sensitivity and specificity of the assays have allowed for an indepth study of the effects of contraceptive steroids on gonadotropin levels, and has given us increased understanding of the mechanism of action of these anovulatory compounds. Progestational compounds, in doses usually utilized for contraceptive purposes, inhibit ovulation primarily by inhibition of the mid-cycle surge of LH. Only in larger dosages is there any effect on FSH. Estrogens, on the other hand, in adequate doses act primarily on FSH but in dosages usually utilized in current products inhibit the mid-cycle surge of LH as well.

The second portion of the discussion will be devoted to the experimental use of different dosage regimens to attempt to prevent ovarian overstimulation subsequent to gonadotropin therapy. Finally, the prognostic significance of estrogen excretion levels will be presented.

HOWARD PYLE

Chicago, Illinois



HOWARD PYLE, President of the National Safety Council, will open the symposium on Automotive Safety at the General Scientific Meeting Tuesday, May 6.

Before joining the National Safety Council, Mr. Pyle spent 25 years as a radio correspondent and broadcasting executive in Phoenix, Arizona. During those years, he personally covered the Pacific combat zones of World War II, including the Japanese surrender aboard the Battleship Missouri, as well as the World Security Conference held in San Francisco in 1945.

He was elected Governor of Arizona in 1951, and was re-elected to a second term in 1953. During this period, he was twice Chairman of the Western Governors Conference, as well as vice chairman of the

National Governors' Conference Committee for promotion and formation of the present expanded national highway construction program.

In 1955 he was named Deputy Assistant to the President of the United States for Federal-State Relations. In this capacity, one of his many responsibilities was that of planning contact for the President's Committee for Traffic Safety. This, coupled with his previous gubernatorial interest in safety, gave him a comprehensive understanding of the nation's accident prevention problem. A short summary of his paper, "Safety's First Commitment Is Prevention," follows:

Although safety involves more than one phase of protection for men, women and children, its first and most important commitment is prevention of the incident that accidentally kills or injures.



FLETCHER N. PLATT

Ann Arbor, Michigan

FLETCHER N. PLATT, manager of Ford Motor Company's Traffic Safety and Highway Improvement Department, will participate in the Symposium on Automotive Safety on Tuesday, May 6, 1969.

Mr. Platt joined the company in 1950 in the Ford Division Truck Sales Department. He soon was promoted to the Marketing Staff and later served as a product planning assistant in the Executive Office.

An inventor, Mr. Platt recently designed and developed the Ford Sentinel, an experimental driver aid which warns the driver if he becomes erratic in his driving. He is also credited with the development of the time-lapse driver education filmstrip series produced by Ford and used widely throughout the United States.

Mr. Platt is a director of the Traffic Safety Association of Detroit and a member of the Board of Directors of the National Safety Council. He also is a member of the Society of Automotive Engineers, Institute of Traffic Engineers, American Institute of Aeronautics, and Astronautics and Human Factors Society. In addition, he is the author of numerous

papers on highway systems, driver behavior and traffic characteristics.

The subject of Mr. Platt's paper, to be presented at 2:30 p.m., is "Highway Systems Research Car, Data and Analysis." An abstract follows:

The Highway Systems Research (HSR) car, developed by Ford's Traffic Safety and Highway Improvement Department, on the outside looks like any other 1969 Mercury convertible. Inside, it has an array of electronic equipment, sensors, counters and a gold-plated steering wheel that picks up driver stress and pulse.

Sensors are connected to a 20-channel programmed magnetic tape recorder in the car's trunk. The tape is fed directly into a computer for analysis of the driver and the car. Thus, both physiological characteristics and skill of the driver in various traffic, road and weather conditions are recorded and evaluated.

Since November 1967, the HSR car has been used cross-country for a number of research projects. Participating organizations include: Insurance Company of North America, Pennsylvania Department of Instruction, Texas A & M, University of California (UCLA) and Iowa State University. By invitation from the White House Secret Service, the HSR car also was employed in a special driver evaluation program involving a selected number of Secret Service personnel.

Preliminary results indicate that HSR instrumentation provides a common set of variables which for the first time tie together research of traffic, highway and automotive engineers, and medical and driver education experts.

ROY C. HAEUSLER

Detroit, Michigan



ROY C. HAEUSLER is Chief Engineer for Automotive Safety with the Chrysler Corporation. He will speak at 3:00 on Tuesday, May 6 at the Symposium on Automotive Safety.

Mr. Haeusler received his Engineering and Business Administration degree from the Massachusetts Institute of Technology in 1932, and joined the Chrysler Corporation in 1934. In 1955, he established the office of Automotive Safety Engineering, with the basic assignment of taking appropriate steps to maintain and build Chrysler Corporation's reputation with regard to automotive safety. This as-

signment has resulted in the need for working with product planning, styling and merchandising personnel, as well as with the engineers, and for working with the many traffic safety organizations in the U.S. and Canada, as well as the engineering societies.

The development of safety performance standards for vehicles and for equipment has been an important part of Mr. Haeusler's work. He is Chairman of the Automotive Safety Committee of the Society of Automotive Engineers and Chairman of the Motor Vehicle Safety Standards Committee of the United States of America Standards Institute.

Woman's Auxiliary Medical Association of Georgia

44th Annual Meeting



PRESIDENT'S GREETING

IT IS TRULY a great pleasure and privilege for me as your President to welcome you to our 44th Annual Convention of the Woman's Auxiliary to the Medical Association of Georgia.

Historic and beautiful Savannah, Georgia's first colonial capital, is a delightful setting for our meeting. I should like to thank our members who have been untiring in their efforts to make our visit enjoyable and memorable.

It is my hope, and theirs, that each of us will remember this Convention for its spirit of fellowship, its pride in past accomplishments and for its enthusiasm for continued service toward realizing our Auxiliary Horizons.

Most sincerely,
Mrs. Hayward S. Phillips, *President*
Woman's Auxiliary to the
Medical Association of Georgia



WELCOME TO SAVANNAH

TO ALL MEMBERS of the Woman's Auxiliary to the Medical Association of Georgia, it is my honored privilege to extend to you, in behalf of the Physicians' wives of the Georgia Medical Society a very cordial invitation to attend the 44th Annual Convention of the Woman's Auxiliary to the Medical Association of Georgia. It will be our pleasure to assist you in any way that will make your visit in Savannah a happy and interesting one.

Sincerely,
Mrs. Lehman W. Williams,
Past President
Woman's Auxiliary to the
Medical Association of Georgia

The Program

SUNDAY, MAY 4

- 11:00 Registration and Information**
to *Convention Lobby*
- 5:00** *DeSoto Hilton*
Hospitality and Exhibits
Rooms 217-218
- 12:00 Pre-Convention Executive Board Meeting—Dutch Luncheon**
South Harborview Room
PRESIDING—MRS. HAYWARD S. PHILLIPS, Augusta, *President*, Woman's Auxiliary to the MAG
INVOCATION—MRS. JOHN KEMBLE, *President*, Baldwin County Auxiliary
PLEDGE OF LOYALTY AND COLLECT—MRS. EARL T. MCGHEE, Dalton, *First Vice President*
- 1:00 MAG General Business Session**
Ballroom, Savannah Inn
(All MAG and Auxiliary Members Invited)
PRESIDING—CHARLES R. ANDREWS, JR., M.D., Canton, *President*
- 3:00 Tour of Savannah**
to (Husbands and Children Welcome)
- 5:00**
MAG Specialty Society Receptions and Dinners
(See MAG Program)

MONDAY, MAY 5

- 8:00 Registration and Information**
to *Convention Lobby*
- 5:00** *DeSoto Hilton Hotel*
Hospitality and Exhibits
Rooms 217-218
- 9:00 MAG General Business Session and House of Delegates Meeting**
Ballroom, Savannah Inn
(All MAG and Auxiliary Members and Guests Invited)
PRESIDING—CHARLES R. ANDREWS, JR., M.D., Canton, *President*
REPORT OF WOMAN'S AUXILIARY TO MAG—MRS. S. WILLIAM CLARK, Waycross, *President-Elect*

9:30 Auxiliary General Meeting

- Harborview Room, DeSoto Hilton*
CALL TO ORDER—MRS. HAYWARD S. PHILLIPS, Augusta, *President*
INVOCATION—DR. FORREST LANIER, Pastor, First Baptist Church, Savannah
PLEDGE OF LOYALTY AND COLLECT—MRS. W. JACK SMITH, *President*, Glynn County Auxiliary
ADDRESS OF WELCOME—MRS. LEHMAN H. WILLIAMS, Savannah, *Past President*
RESPONSE TO WELCOME—MRS. JOHN BATES, *President*, Randolph-Stewart-Terrell Auxiliary
PRESENTATION OF CONVENTION PLANS—MRS. JOHN KIRK TRAIN, Savannah, *Convention Chairman*
INTRODUCTION OF PAGES FOR THE DAY—MRS. JOHN L. ELLIOTT, Savannah, *Past President*
REPORT OF ADVISORY COMMITTEE TO THE WOMAN'S AUXILIARY TO THE MAG—W. C. MITCHELL, M.D., *Chairman*, Smyrna

Greetings

- PRESIDENT OF MAG—CHARLES R. ANDREWS, JR., M.D., Canton
PRESIDENT-ELECT OF MAG—JOHN KIRK TRAIN, M.D., Savannah
INTRODUCTION OF PAST PRESIDENTS AND GUESTS—MRS. LUTHER H. WOLFF, Columbus, *Past President*

Business Session

- (All reports limited to two minutes)
CONVENTION RULES OF ORDER—MRS. RALPH H. CHANEY, SR., Augusta, *Parliamentarian*
ROLL CALL AND MINUTES—MRS. NEAL F. YEOMANS, Waycross, *Secretary*
TREASURER'S REPORT (Including Auditor's Report)—MRS. C. JAMES ROPER, Jasper, *Treasurer*
PRESIDENT'S REPORT—MRS. HAYWARD S. PHILLIPS, Augusta, *President*
PRESIDENT-ELECT'S REPORT—MRS. S. WILLIAM CLARK, Waycross, *President-Elect*
ADDENDUM REPORTS—State Officers and Chairmen (Complete reports are published in the 1968-69 Annual Report Book)

RECOMMENDATIONS FROM THE EXECUTIVE BOARD—MRS. NEAL F. YEOMANS, Waycross, *Secretary*

REPORT OF THE REVISIONS COMMITTEE—MRS. JOHN T. LESLIE, *Past President*, Avondale Estates, *Chairman*

REPORT OF THE CREDENTIALS COMMITTEE—MRS. LOUIE H. GRIFFIN, SR., *Past President*, Claxton, *Chairman*

ANNOUNCEMENTS

MEMORIAL SERVICE—MRS. JOHN B. RABUN, Savannah

12:00 Recess of Session

12:00 MAG General Assembly

Ballroom, Savannah Inn

(All MAG and Auxiliary Members and Guests Invited)

12:30 Luncheon and Fashion Show

Center and South Ballroom, DeSoto Hilton Hotel

PRESIDING—MRS. HAYWARD PHILLIPS, Augusta, *President*

INVOCATION—MRS. ROBERT M. FLOWERS, *President*, Muscogee County Auxiliary

3:00 Boat Ride

(Husbands and Children Welcome)

**Eve- Alumni Receptions and Dinners
ning and other Alumni Functions**

TUESDAY, MAY 6

8:00 Registration and Information

to *Convention Lobby, DeSoto Hilton*

5:00

Hospitality and Exhibits

Rooms 217-218

9:30 Auxiliary General Meeting

Harborview Room, DeSoto Hilton

CALL TO ORDER—MRS. HAYWARD S. PHILLIPS, *President*

INVOCATION—RABBI ABRAHAM I. ROSENBERG, Spiritual Leader, Congregation of B'nai B'rith Jacob, Savannah

PLEDGE OF LOYALTY AND COLLECT—MRS. WILLIAM O. WILLIAMS, JR., *President*, Bibb County Auxiliary

INTRODUCTION OF PAGES FOR THE DAY—MRS. JOHN ELLIOTT, Savannah, *Past President*

ANNOUNCEMENTS

BUSINESS SESSION

MINUTES—MRS. NEAL F. YEOMANS, Waycross, *Secretary*

REPORT OF THE REVISIONS COMMITTEE—MRS. JOHN T. LESLIE, *Past President*, Avondale Estates, *Chairman*

REPORT OF THE BUDGET AND FINANCE COMMITTEE—MRS. MURRAY LUMPKIN, Dalton, *Chairman*

REPORT OF THE RESOLUTIONS COMMITTEE—MRS. RONALD F. GALLOWAY, *President*, Richmond County Auxiliary, *Chairman*

REPORT OF THE CREDENTIALS COMMITTEE—MRS. LOUIE H. GRIFFIN, SR., *Past President*, Claxton, *Chairman*

REPORT OF THE COURTESY COMMITTEE—MRS. GEORGE HARRISON, *President*, Cobb County Auxiliary, *Chairman*

INTRODUCTION OF GUEST SPEAKER—MRS. PERRY M. WHITE, *President*, Fulton County Auxiliary

ADDRESS—MRS. AMOS N. JOHNSON, *Director*, Woman's Auxiliary to AMA, Garland, North Carolina

REPORTS OF THE AWARDS

COMMITTEES—

Achievement—MRS. GEORGE W. STRATHAM, Decatur, *Chairman*

Safety and Disaster Preparedness—MRS. RUPERT H. BRAMBLETT, Cumming, *Chairman*

AMA-ERF—MRS. BENJAMIN BASHINSKI, JR., Macon, *Chairman*

Mrs. J. Bonar White Scrapbook—MRS. CHARLES R. SMITH, *Second Vice President*, *Chairman*

James N. Brawner, M.D., Trophy for General Excellence—MRS. JAMES H. MANNING, *Past President*, Marietta, *Chairman*

Doctor's Day—MRS. CLIFF MOORE, Rome, *Chairman*

REPORT OF MAG CONVENTION—PRESTON D. ELLINGTON, M.D., *Chairman*, MAG Annual Sessions Committee

REPORT OF NOMINATING COMMITTEE—MRS. JAMES H. MANNING, Marietta, *Chairman*

ELECTION OF OFFICERS

INSTALLATION OF OFFICERS—MRS. JOHN A. MEIER, Albany, *Past President*

INAUGURAL ADDRESS AND ANNOUNCEMENTS OF 1969-1970

STATE CHAIRMEN—MRS. S. WILLIAM CLARK, JR., Waycross, *President*

PRESENTATION OF PAST PRESIDENT'S PIN—MRS. JAMES H. MANNING, Marietta

ANNOUNCEMENTS

12:30 Adjournment

1:00 Luncheon for Members and Guests

Center Ballroom, DeSoto Hilton Hotel

PRESIDING—MRS. S. WILLIAM CLARK, JR., Waycross, *President*

INVOCATION—MRS. CHARLES R. ANDREWS, JR., *President*, Cherokee-Pickens Auxiliary, Canton

GUEST SPEAKER—"Antiques"—MR.
JAMES A. WILLIAMS, Savannah, Author-
ity on Interior Design and Restorations

1:00 Past-Presidents' Luncheon (Dutch)
The Sign of the White Hart

PRESIDING—MRS. JAMES H. MANNING,
Past President

**6:30 Georgia Medical Society Social
Hour**

Poolside, Savannah Inn

(All MAG Members, Their Wives and
Exhibitors Invited)

8:00 Annual Banquet

Ballroom, Savannah Inn

WEDNESDAY, MAY 7

**9:00 Post-Convention Executive Board
to
12:00 Breakfast (Dutch) and School
of Instruction**

*South Harborview Room, DeSoto Hilton
Hotel*

PRESIDING—MRS. S. WILLIAM CLARK,
Waycross, President

9:00 MAG General Session

Ballroom, Savannah Inn

(All MAG and Auxiliary Members and
Guests Invited)

PRESENTATION OF AWARDS AND
INSTALLATION OF OFFICERS

Rules to Govern the Convention

1. The voting body of the convention shall consist of the members of the Executive Board of the Woman's Auxiliary to the Medical Association of Georgia and the duly accredited delegates from the county auxiliaries. No one is entitled to vote until registered.
 2. To gain recognition, a delegate is requested to rise, address the chair, give her name and the name of her auxiliary.
 3. No delegate shall speak more than twice on the same subject, and is limited to two minutes each time.
 4. Badges must be worn by members of the voting body during all general sessions of the convention.
 5. Delegates' privileges are not transferable.
 6. All motions shall be presented in writing to the Recording Secretary. They shall be signed by persons making and seconding the motion.
 7. All original motions on resolutions shall be made by submitting two copies, one to the Resolution Committee and one to the Recording Secretary.
 8. All persons appearing on the program must be seated near the platform when the session opens.
- Whispering greatly retards the business of the meeting. Order must be maintained at all times. Please be prompt. Meetings will begin promptly at the time announced.

CONVENTION COMMITTEES

General Chairman

Mrs. Kirk Train

Co-Chairman

Mrs. Walter E. Brown

Printing

Mrs. Frank Hoffman

Tellers

Mrs. Russell Andrews, Jr., Rome
Mrs. James Hubert Milford, Hartwell
Mrs. David E. Tanner, Savannah

Timekeepers

Mrs. Hubert F. Anthony, Thomaston
Mrs. Jack B. Lindley, Augusta

Reading Committee

Mrs. Robert M. Finc, Decatur
Mrs. William J. Hardman, Athens
Mrs. Henry D. Scoggins, Augusta

Art Exhibit

Chairman, Mrs. Peter Scardino
Co-Chairmen, Mrs. Lamont Osteen
Mrs. Emanuel Rosen

Credentials

Mrs. Louie H. Griffin, Sr., Claxton

Registration

Mrs. David Fillingim
Mrs. Hollis Puckett

Publicity

Mrs. John B. Rabun

Memorial Service

Mrs. John B. Rabun, Savannah

Hospitality and Display Room

Mrs. Henry Frech

Welcome Committee

Chairman, Mrs. Lehman Williams
Co-Chairmen, Mrs. Lawrence Bodziner
Mrs. Herman Delancy

Pages

Mrs. John Elliott
Mrs. David W. Fillingim

Luncheon Coordinator
Mrs. Dicky Timms

**Executive Board
Pre-Convention Luncheon**

Mrs. Herman Delancy

**Monday Luncheon and
Fashion Show**

Mrs. William Miller

**Tuesday Luncheon and
"Antiques" Program**

Mrs. J. Robert Logan

**Post-Convention Breakfast and
School of Instruction**

Mrs. Richard Schulze

Banquet

Mrs. Eliot Cobb
Mrs. Randall Winburn, Jr.

WOMAN'S AUXILIARY TO THE MEDICAL ASSOCIATION OF GEORGIA 1968-69

Officers

<i>President</i>	MRS. HAYWARD S. PHILLIPS 1082 Bertram Road, Augusta, Ga. 30904
<i>President-Elect</i>	MRS. S. WILLIAM CLARK, JR. 1409 Satilla Boulevard, Waycross, Ga. 31501
<i>First Vice-President</i>	MRS. EARL T. MCGHEE 808 Atkinson Drive, Dalton, Ga. 30720
<i>Second Vice-President</i>	MRS. CHARLES R. SMITH 2620 Foley Drive, Columbus, Ga. 31906
<i>Third Vice-President</i>	MRS. Z. SWEENEY SIKES 259 Idlewild Road, Macon, Ga. 31204
<i>Recording Secretary</i>	MRS. NEAL F. YEOMANS 602 Magnolia Street, Waycross, Ga. 31501
<i>Corresponding Secretary</i>	MRS. HARRY B. O'REAR 3069 Hillsdale Road, Augusta, Ga. 30904
<i>Treasurer</i>	MRS. C. JAMES ROPER 992 South Main St., Jasper, Ga. 30143
<i>Historian</i>	MRS. CARL S. PITTMAN, JR. 415 W. 18th St., Tifton, Ga. 31794
<i>Parliamentarian</i>	MRS. RALPH H. CHANEY, SR. 3118 Bransford Road, Ext., Augusta, Ga. 30904

Chairmen of Standing Committees

<i>Achievement Award</i>	MRS. GEORGE STATHAM 2211 Hill Park Court, Decatur, Ga. 30033
<i>AMA-ERF</i>	MRS. BENJAMIN BASHINSKI, JR. 445 Lamar Drive, Macon, Ga. 31204
<i>AMA-ERF (Co-Chairman)</i>	MRS. EVANS NICHOLS 580 Hillandale Circle, Marietta, Ga. 30060
<i>Archives</i>	MRS. PRENTISS E. PARKER 134 McDonald Street, Marietta, Ga. 30060
<i>James N. Brawner, Sr., M.D. Trophy</i>	MRS. JAMES H. MANNING 643 Kennesaw Avenue, Marietta, Ga. 30060
<i>Budget and Finance</i>	MRS. MURRAY LUMPKIN 407 W. Emory Street, Dalton, Ga. 30720
<i>Community Service</i>	MRS. CHARLES R. SMITH 2620 Foley Drive, Columbus, Ga. 31906
<i>Doctor's Day</i>	MRS. CLIFF MOORE, JR. 5 East Ridge Court, Rome, Ga. 30161
<i>Editorial (Pulse Line)</i>	MRS. PIERRE N. LEVIN Apt. 15, 135 Hill Street, Decatur, Ga. 30030
<i>Health Careers</i>	MRS. W. A. MENDENHALL 3830 Chamblee-Dunwoody Road, Chamblee, Ga. 30005
<i>Health Careers (Co-Chairman)</i>	MRS. PAUL W. LUCAS 617 Wilson Street, Tifton, Ga. 31794
<i>Health Careers (Co-Chairman)</i>	MRS. JAMES J. McDONALD 160 Holly Falls Drive, Athens, Ga. 30601
<i>International Health</i>	MRS. ALBERTO C. MARTINEZ P.O. Box 677, Milledgeville, Ga. 31061
<i>Legislation</i>	MRS. Z. SWEENEY SIKES, JR. 259 Idle Wild Road, Macon, Ga. 31204
<i>Membership</i>	MRS. S. WILLIAM CLARK, JR. 1409 Satilla Boulevard, Waycross, Ga. 31501
<i>Mental Health</i>	MRS. NORMAN B. PURSLEY 3427 Old Savannah Road, Augusta, Ga. 30906
<i>Program</i>	MRS. EARL T. MCGHEE 808 Atkinson Drive, Dalton, Ga. 30720
<i>Research and Romance of Medicine</i>	MRS. EDWIN H. GRANT Bankhead Highway, Carrollton, Ga. 30117
<i>Revisions</i>	MRS. JOHN T. LESLIE 19 Wiltshire Dr., Avondale Estates, Ga. 30002
<i>Rural Health</i>	MRS. JOHN BATES 515 Court Street, Cuthbert, Ga. 31740
<i>Safety-Disaster Preparedness</i>	MRS. RUPERT H. BRAMBLETT P.O. Box 737, Cumming, Ga. 30130
<i>Scrapbook</i>	MRS. LOUIS A. HAZOURI 2732 Techwood Drive, Columbus, Ga. 31906
<i>William R. Dancy, M.D. Student Loan Fund</i>	MRS. WILLIAM N. AGOSTAS 2302 Overton Road, Augusta, Ga. 30904
<i>William R. Dancy, M.D. Student Loan Fund (Co-Chairman)</i>	MRS. JACK B. LINDLEY 2219 Glendale Road, Augusta, Ga. 30904

Chairmen of Special Committees

<i>Crawford W. Long Notepaper</i>	MRS. DAVID E. TANNER 20 Tiffany Place, Savannah, Ga. 31406
<i>Woman's Auxiliary to Student American Medical Association (WA-SAMA) Liaison</i>	MRS. F. JAMES FUNK, JR. 3407 Woodhaven Road, N. W., Atlanta, Ga. 30305
<i>WA-SAMA Co-Liaison</i>	MRS. HENRY D. SCOGGINS 3107 Vassar Drive, Augusta, Ga. 30904
<i>Representative to GAMPAC</i>	MRS. LUTHER M. VINTON, JR. 1043 Lakeshore Drive, Avondale Estates, Ga. 30002

Advisory Committee from the Medical Association of Georgia

William C. Mitchell, M.D., <i>Chairman</i>	104 Sunset Avenue Smyrna, Ga. 30080
Charles R. Andrews, Jr., M.D., <i>Ex-Officio</i>	201 Park View Drive Canton, Ga. 30114
John Kirk Train, Jr., M.D., <i>Ex-Officio</i>	1107 Bull Street Savannah, Ga. 31401
Braswell E. Collins, M.D., <i>Liaison, AMA-ERF</i>	740 Hemlock Street Macon, Ga. 31204
S. William Clark, Jr., M.D.	P.O. Box 951 Waycross, Ga. 31501
Louie H. Griffin, Sr., M.D.	P.O. Box 547 Claxton, Ga. 30417
James H. Manning, M.D.	605 Roswell Road Marietta, Ga. 30062
Hayward S. Phillips, M.D.	1082 Bertram Road Augusta, Ga. 30904

District Councilors

<i>First District</i> —MRS. C. EMORY BOHLER	P.O. Box 8, Brooklet, Ga. 30415
<i>Second District</i> —MRS. J. DANIEL BATEMAN	2105 Beattie Road, Albany, Ga. 31701
<i>Third District</i> —MRS. A. J. MORRIS	119 Walnut Street, Montezuma, Ga. 31063
<i>Sixth District</i> —MRS. MAX MASS	3844 The Prado, Macon, Ga. 31204
<i>Seventh District</i> —MRS. PAUL L. BRADLEY	410 Cuyler Street, Dalton, Ga. 30720
<i>Eighth District</i> —MRS. ROBERT E. PERRY	4113 Riverside Drive, Brunswick, Ga. 31520
<i>Ninth District</i> —MRS. IRVING HELLENGA	Toccoa, Ga. 30577
<i>Tenth District</i> —MRS. WILLIAM A. WILKES	1203 Highland Avenue, Augusta, Ga. 30904

Councilor to Southern Medical Association

MRS. CLIFF MOORE, JR.
5 Ridge Court, Rome, Ga. 30163

The Medical Association of Georgia Related Committees

<i>Allied Health Careers</i>	John T. Godwin, M.D., <i>Chairman</i> 265 Ivy Street N.E., Atlanta, Ga. 30303
<i>Disaster Medical Care</i>	Virgil B. Williams, M.D., <i>Chairman</i> 571 S. 9th Street, Griffin, Ga. 30223
<i>Legislation</i>	J. Frank Walker, M.D., <i>Chairman</i> 1293 Peachtree Street N.E., Atlanta, Ga. 30309
<i>Mental Health</i>	Julius T. Johnson, M.D., <i>Chairman</i> 1445 Harper Street, Augusta, Ga. 30902
<i>Rural Health</i>	Thomas N. Lumsden, M.D., <i>Chairman</i> P.O. Box 297, Clarkesville, Ga. 30523

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<i>Baldwin</i>	President, Mrs. John W. Kemble Central State Hospital, Milledgeville, Ga. 31062
	President-Elect, Mrs. William Wood Central State Hospital, Milledgeville, Ga. 31062
<i>Bibb</i>	President, Mrs. W. O. Williams, Jr. 430 Pine Vista, Macon, Ga. 31204
	President-Elect, Mrs. Milton Johnson, Jr. 3017 Stuart Drive, Macon, Ga. 31204
<i>Bulloch-Candler-Evans</i>	President, Mrs. Leon E. Curry 430 Williams Street, Metter, Ga. 30439
	President-Elect, Mrs. Charles R. Richardson 517 Donehoo Street, Statesboro, Ga. 30458
<i>Carroll-Douglas-Haralson</i>	President, Mrs. T. M. Martin, Jr. Forrest Road, Carrollton, Ga. 30117
	President-Elect, Mrs. Phil C. Astin 516 Cedar Street, Carrollton, Ga. 30117
<i>Cherokee-Pickens</i>	President, Mrs. Charles R. Andrews, Jr. 201 Park View Drive, Canton, Ga. 30114
	President-Elect, Mrs. William H. Nichols Sunset Drive, Canton, Ga. 30114

Clarke (Crawford W. Long) President, Mrs. William J. Hardman
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President-Elect, Mrs. Donald L. Branyon
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President-Elect, Mrs. Paul Payne
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Coffee President, Mrs. William R. Wills, Jr.
Kellogg Sub-Division, Douglas, Ga. 31533
President-Elect, Mrs. Calvin Stewart Meeks, Jr.
Ocilla Road, Douglas, Ga. 31533

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201 Greenview Road, Rome, Ga. 30161

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Riverside Drive, Brunswick, Ga. 31520

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Elenor Circle, Perry, Ga. 31069

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515 Court Street, Cuthbert, Ga. 31740

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818 Windsor Court, Augusta, Ga. 30904
President-Elect, Mrs. Herbert S. Harper
996 Campbellton Drive, N. Augusta, S.C. 29841

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Lexington Street, Lyons, Ga. 30436

Southwest Georgia President, Mrs. Homer P. Wood
Fort Gaines, Ga. 31751

Stephens President, Mrs. Kenneth Conoley
831 Rosedale Lane, Toccoa, Ga. 30577

Sumter-Schley-Macon President, Mrs. Harvey L. Simpson
Eckles Road, Americus, Ga. 31709
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Ellaville, Ga. 31806

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188 Watson Street, Thomasville, Ga. 31792
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109 Pastime Drive, Thomasville, Ga. 31792

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415 West 18th Street, Tifton, Ga. 31794
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Carolina Drive, Tifton, Ga. 31794

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Country Club Road, LaGrange, Ga. 30240
President-Elect, Mrs. Alvah Nelson
Gordon Street, LaGrange, Ga. 30240

Upton President, Mrs. H. F. Anthony, Jr.
712 S. Center Street, Thomaston, Ga. 30286
President-Elect, Mrs. Joel F. Mikell
105 Johnston Drive, Thomaston, Ga. 30286

Walker-Catoosa-Dade President, Mrs. Murphy K. Cureton
6 Sunset Drive, Lafayette, Ga. 30728
President-Elect, Mrs. Garland Eugene Kinard
Chickamauga, Ga. 30707

Ware President, Mrs. J. Warren Bickerstaff
1506 N. City Boulevard, Waycross, Ga. 31501
President-Elect, Mrs. Thomas Joseph Ferrell, Jr.
1113 Cherokee Circle, Waycross, Ga. 31501

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108 Alma Drive, Dalton, Ga. 30720
President-Elect, Mrs. Ronald Tipton
905 Rockdale Drive, Dalton, Ga. 30720

Worth President, Mrs. W. P. Stoner
Moore Street, Sylvester, Ga. 31791
President-Elect, Mrs. J. L. Tracy, Jr.
508 N. Main Street, Sylvester, Ga. 31791

Past Presidents and Conventions

Honorary Presidents for Life

Mrs. James N. Brawner, Sr., Atlanta
Mrs. Eustace A. Allen, Atlanta
Mrs. William R. Dancy, Savannah
Mrs. Ralph H. Chaney, Sr., Augusta

1924—Augusta (Organization)—Mrs. C. W. Roberts, Atlanta (Deceased), Temporary Chairman
1925—Atlanta—Mrs. James N. Brawner, Sr., Atlanta
1926—Albany—Mrs. William H. Myers, Savannah
1927—Athens—Mrs. C. W. Roberts, Atlanta (Deceased)
1928—Savannah—Mrs. Paul Holiday (Mrs. J. C. Moore, Gaffney, S. C.)
1929—Macon—Mrs. Charles C. Hinton, Macon
1930—Augusta—Mrs. Marion T. Benson, Atlanta (Deceased)
1931—Macon—Mrs. Charles C. Harrold, Macon (Deceased)
1932—Savannah—Mrs. Ralston Lattimore, Savannah
1933—Macon—Mrs. S. T. R. Revell, Louisville
1934—Augusta—Mrs. J. Bonar White, Atlanta (Deceased)
1935—Atlanta—Mrs. J. E. Penland, Waycross
1936—Savannah—Mrs. Ernest R. Harris, Winder (Deceased)
1937—Macon—Mrs. W. R. Dancy, Savannah
1938—Augusta—Mrs. Ralph H. Chaney, Sr., Augusta
1939—Atlanta—Mrs. Warren A. Coleman, Eastman
1940—Savannah—Mrs. Eustace A. Allen, Atlanta
1941—Macon—Mrs. H. G. Bannister, Ila
1942—Augusta—Mrs. Lee Howard, Savannah
1943—Atlanta—Mrs. J. Lon King, Macon
1944—Savannah—Mrs. Olin S. Cofer, Atlanta
1945—No Convention
1946—Macon—Mrs. W. T. Randolph, Winder
1947—Augusta—Mrs. W. Bruce Schaefer, Toccoa
1948—Atlanta—Mrs. W. G. Elliott, Cuthbert
1949—Savannah—Mrs. S. A. Anderson, Atlanta
1950—Macon—Mrs. J. Harry Rogers, Atlanta
1951—Augusta—Mrs. Lehman W. Williams, Savannah
1952—Atlanta—Mrs. J. R. S. Mays, Macon
1953—Savannah—Mrs. Ralph W. Fowler, Marietta (Deceased)
1954—Macon—Mrs. Leo Smith, Waycross
1955—Augusta—Mrs. Shelley C. Davis, Atlanta
1956—Atlanta—Mrs. Robert C. Major, Augusta
1957—Savannah—Mrs. Walker L. Curtis, College Park
1958—Macon—Mrs. John L. Elliott, Savannah
1959—Augusta—Mrs. Luther H. Wolff, Columbus
1960—Columbus—Mrs. Remer Y. Clark, Marietta
1961—Atlanta—Mrs. W. P. Rhyne, Albany
1962—Savannah—Mrs. A. Worth Hobby, Atlanta
1963—Jekyll Island—Mrs. E. W. Waldemayer, Chamblee
1964—Macon—Mrs. John E. Porter, Savannah
1965—Augusta—Mrs. John T. Leslie, Avondale Estates
1966—Columbus—Mrs. Louie H. Griffin, Sr., Claxton
1967—Atlanta—Mrs. John Meier, Albany
1968—Augusta—Mrs. James H. Manning, Marietta

ART SHOW

FIRST PHYSICIANS' ART EXHIBIT

SAVANNAH INN & COUNTRY CLUB

MAY 3 THRU 6

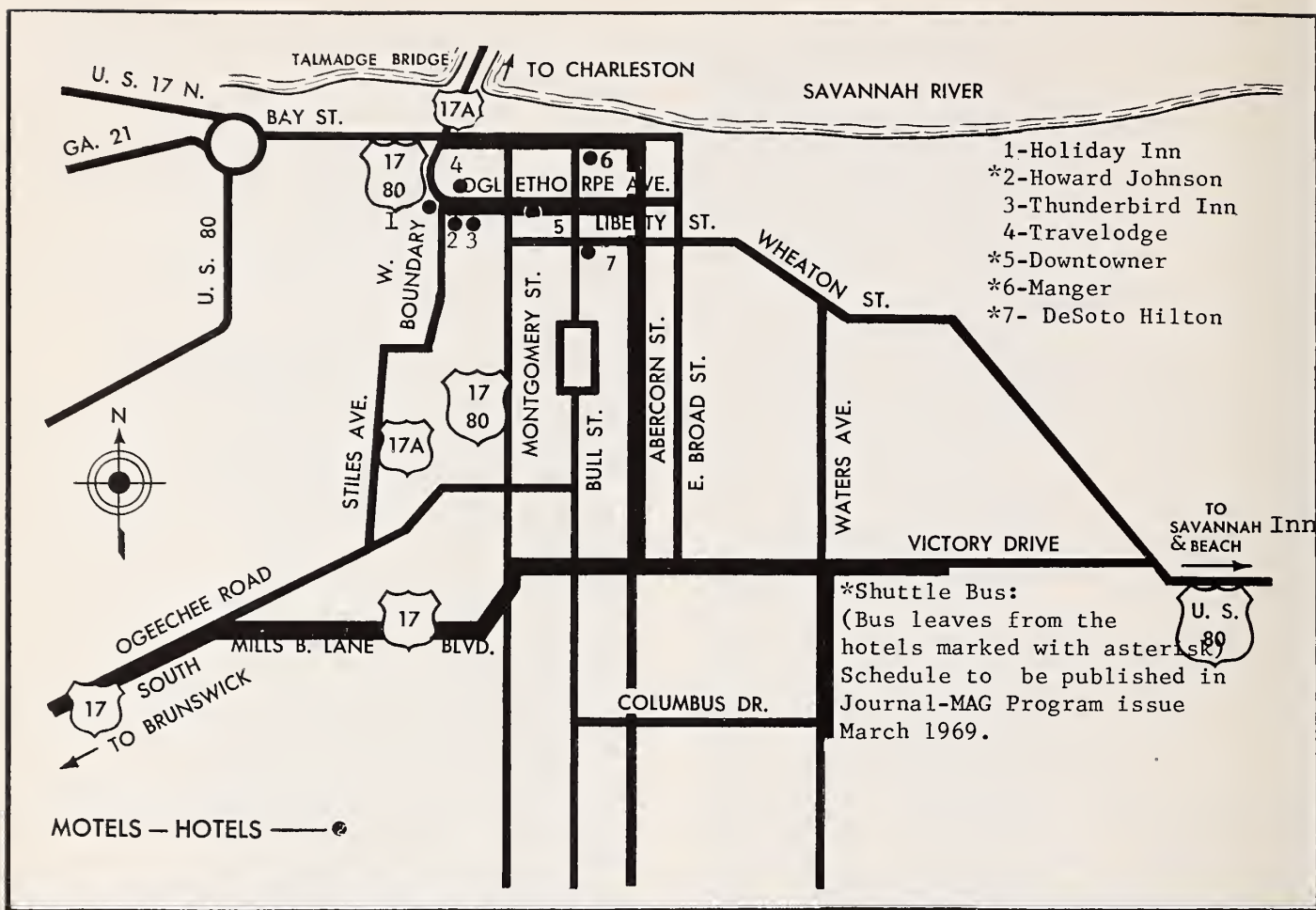
Paintings, sculpture and photographs
ELIGIBLE: Physicians and immediate families

For application forms write either:

Mrs. Peter L. Scardino
125 East 45th Street

or

Mrs. Lamont Osteen
3601 Abercorn Street
Savannah, Ga. 31405



MONDAY, MAY 5 & TUESDAY, MAY 6

<i>Howard Johnson's</i>	<i>Manger</i>	<i>Downtowner</i>	<i>DeSoto Hilton</i>	<i>Savannah Inn & CC</i>
<i>LEAVING TIMES FROM LOCATIONS INDICATED</i>				
7:15 a.m.	7:25 a.m.	7:35 a.m.	7:45 a.m.	8:15 a.m.
8:00	8:10	8:20	8:30	9:00
8:45	8:55	9:05	9:15	9:45
9:30	9:40	9:50	10:00	10:30
10:15	10:25	10:35	10:45	11:15
11:00	11:10	11:20	11:30	12:00
11:45	11:55	12:05 p.m.	12:15 p.m.	12:45 p.m.
12:30 p.m.	12:40 p.m.	12:50	1:00	1:30
1:15	1:25	1:35	1:45	2:15
2:00	2:10	2:20	2:30	3:00
2:45	2:55	3:05	3:15	3:45
3:30	3:40	3:50	4:00	4:30
4:15	4:25	4:35	4:45	5:15
5:00	5:10	5:20	5:30	
5:45	5:55	6:05	6:15	

WEDNESDAY, MAY 7

<i>Howard Johnson's</i>	<i>Manger</i>	<i>Downtowner</i>	<i>DeSoto Hilton</i>	<i>Savannah Inn & CC</i>
<i>LEAVING TIMES FROM LOCATIONS INDICATED</i>				
8:00 a.m.	8:10 a.m.	8:20 a.m.	8:30 a.m.	9:00 a.m.
9:30	9:40	9:50	10:00	10:30
11:00	11:10	11:20	11:30	12:00
12:30 p.m.	12:40 p.m.	12:50 p.m.	1:00 p.m.	

On Sunday May 4, buses will follow the same schedule, with the first bus leaving Howard Johnson's at 9:30 a.m.

For Your MAG 1969 Annual Session

Hotel and Motel Reservations

APPLICATION FOR HOTEL AND MOTEL ACCOMMODATIONS

Medical Association of Georgia, 115th Annual Session

May 4-7, 1969—Savannah, Georgia

A HOUSING BUREAU has been established for your convenience in making hotel and motel reservations at Savannah for the 1969 Annual Session of the Medical Association of Georgia. Comparable room rates and accommodations information are listed. *Use the Reservation Form below.* Please specify your first, second and third choice. All requests should give anticipated date and hour of arrival; date and approximate hour of departure; names and addresses of all persons who will occupy the accommodations. All reservations must be cleared through the Georgia Medical Society, 612 Drayton Street, Savannah, Georgia 31401. Since all requests for rooms will be handled in chronological order, you should mail your application as early as possible, in order to be certain of obtaining your primary choice. All reservations will be confirmed.

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Georgia's First City

LUCY S. OXNARD, *and*

PETER L. SCARDINO, M.D., *Savannah*

SOME YEARS AGO, Savannah was to travelers one of those unannounced stops to and from Florida. Mechanical failure or fatigue was the drawing card for an overnight stay, and perhaps an impromptu tour to while away time for repairs, on the car or the spirit. Always, there were a dedicated few who returned year after year, to bathe in the tranquility of a city that was slowly going to sleep.

And while she dozed, her citizens were dismantling her in the name of "Progress." Thievery was the order of the day. A house called Habersham, whose front door is now the entrance to the Early American Wing at the Metropolitan Museum in New York, was destroyed to make way for the City Auditorium. That

building is now being replaced by the new Civic Center. The old and charming City Market in Ellis Square, a traditional market place for 200 years, was demolished for a parking garage of questionable design.

The morgue file of lost architecture includes many large and excellent houses remembered by architects as the finest examples of the periods and styles which flourished in Savannah in the 18th and 19th Centuries. These buildings are cited in Frederick Dove-ton Nichols' book, *The Early Architecture of Georgia*, and many others.

Students of design and architecture are familiar with the names of Savannah's most prominent master builders: William Jay and Charles B. Cluskey. Some of their buildings remain; the magnificent Owens-Thomas House, 1818, a regency mansion by Jay, and the imposing "Cluskey Buildings," 1840, face each other across Oglethorpe Square. But there were many small and finely crafted houses, which gave way unnoticed to "Progress," their design and details disappearing forever.

Historic Savannah Foundation

Unrest among Savannahians witnessing the decay and destruction of the central-city area was growing. The magnificent Davenport House was threatened with demolition in 1954. It was occupied then by 16 families, unconditionally a slum. A group of Savannah's leading citizens organized the Historic Savannah Foundation and saved this jewel of late Georgian architecture. The house, begun by Isaiah Davenport in 1815, was fully restored as a museum, opened to the public, and houses the Foundation on the ground floor.



The Sheftall House (ca. 1805-6) was bought in 1817 by Benjamin Sheftall, a member of the first group of Jewish families who came to Savannah in 1733. It was moved to its present site by the Historic Savannah Foundation, Inc., and now faces the Davenport House.

In 1959, what had been a loosely knit organization was turned into a dynamic group with a carefully planned program of community action. Goals were set, and a public-education program initiated to reawaken Savannahians' pride in their rich historic and architectural heritage. Shortly thereafter, the Revolving-Redevelopment Fund concept (using seed money from bank loans), Forward Savannah and private subscriptions implemented a pilot commercial area restoration.

The project was launched in the heart of the business district—the 100 Block of West Congress Street. Demolition of two excellent commercial buildings for a parking lot was threatened. By buying these buildings and leasing them for commercial activity in the area, a program of restoration for the facades of 17 buildings was initiated and is now completed. The plan includes an on-street parking ban, wider retextured sidewalks, trees and greenery planted along the curb, new lighting and rigid sign control.

Residential Revitalization

Following that success in a commercial district, Historic Savannah conceived a 13-acre residential revitalization. The “Pulaski Square—West Jones Street Redevelopment Project” opened in November 1965, and within a year, 35 buildings had been

stabilized and restoration begun. These structures had been multi-family dwellings subjected to absentee ownership neglect and often vacancy. They created fire hazards among other nuisances.

Today, the neighborhood is being transformed from a blighted slum to one of the loveliest residential areas in the city. The new owners, many of whom have small children, have returned to the Historic District the youth and vitality necessary to insure the future stability of an interest in the area for years to come.

While progress continued in these project areas, the Foundation was purchasing other properties throughout the 2.2 square mile Historic District to save them from demolition, and reselling them, with added restrictions, for restoration. The entire Armstrong College complex of seven buildings was launched on a new life in this fashion, and the monies used again to purchase other threatened structures.

The Sheftall House

The new Civic Center Complex mentioned above expanded into several residential blocks, forcing the move of three excellent houses to new locations. The Sheftall House, 1805-6, was moved nearly a mile across town to a lot generously donated for this



Before and After Views: Davenport House—1815-1820. The Davenport House, facing Columbia Square is an unusually beautiful example of late Georgian architecture. The house was restored as a museum in 1954, and is now headquarters for Historic Savannah Foundation, Inc.



GEORGIA'S FIRST CITY / Oxnard



Before and After Views: The Hampton Lillibridge House was built in 1797 for a native of Newport who removed to Savannah after the Revolution and prospered as a merchant and planter. The gambrel roof is reminiscent of Rhode Island houses.

purpose. This house had been the home of Dr. Moses Sheftall, a grandson of Ben Sheftall who landed with Oglethorpe. Dr. Sheftall was one of the early officers of the Board of Health established in 1821 because of the alarm over the continuation of the yellow fever epidemic. He served the city and State in public health, legislative and judicial capacities. His writing showed he had a clear conception of the value of prevention of yellow fever as well as its cure. His house, now facing Columbia Square can be seen by appointment with the Foundation.

East St. Julian Street Area

The efforts of individual restorers have been of tremendous significance to the revitalization of historic properties. The East Saint Julian Street area, with a street finished with crushed oyster shells in the old manner, consists of two blocks of late 18th and early 19th Century houses now almost completely restored. This restoration also includes re-landscaping of Washington and Warren Squares.

Outstanding among these private restorations is the John D. Mongin House built in 1797, and the Hampton Lillibridge House, 1797.

Highlights of the Foundation's accomplishments are too numerous to list, but the most spectacular achievement is the publication of the survey called *Historic Savannah*, a definitive volume on the architectural heritage of Savannah published after six years of extensive study and research. It portrays the history of Savannah from the arrival of the good ship Ann, which carried General Oglethorpe and 114 colonists to the bluff over-looking the Savannah River, to the charm and elegance of the city as it is today.

This magnificent inventory of the Historic District was conducted by a team of experts in the fields of architecture and urban design. The book *Historic Savannah* presents a pictorial catalogue of the 1,100 historic buildings rated in the inventory as "exceptional," "excellent" or "notable."

Impact of Restoration

The impact of restoration on Savannah has greatly increased the city's economic vitality. Over \$6 million has been privately invested in the downtown area. This investment has accomplished the restoration of almost 50 per cent of the buildings that needed repair.

Real estate transactions and construction activities have also picked up. The revitalization has added a significant amount of new assessments to city and county tax rolls, and has been a boon to the central city mercantile and banking district, making the downtown area once again a living city.

The Atlanta Magazine in a recent article says that

Savannah is undergoing a "Renaissance of the Heart," and surely of the major results of restoration, renewed tourist interest is perhaps the greatest. No longer is Savannah, as Lady Astor said, "A lovely lady with a dirty face," for her charm and beauty are again emerging. The variety of her architecture and the grace of her design have gained national recognition.

Outstanding City Plan

Savannah's city plan, designed by Oglethorpe when he founded the colony in 1733, has inspired more than one renaissance of growth and development. Edmund Bacon, eminent city planner of Philadelphia, has called Savannah the most beautiful city in America. In his volume, *Design of Cities*, he further stated, "It is amazing that a colony, struggling against the most elemental problems of survival in a wilderness, should be able to produce a plan, so exalted that it remains as one of the finest diagrams for city organization and growth in existence!"

It is this city plan of boulevards and squares, lined with ranges of handsome buildings and houses of great elegance that has excited the current restoration activity. The success of the recent Capital Fund Campaign Drive for the Foundation underscores the faith of her citizens in this, the rebirth of a city.

Of the more than 1,100 historic buildings within Savannah's Historic District, nearly half have been restored. The reawakening of Savannahians to the beauty that is theirs and the continued leadership of the Foundation with support from other groups will enable the completion of the unique downtown Historic District, providing a total heritage for one of the nation's greatest cities . . . Savannah.

Acknowledgment

The authors wish to thank Mrs. Katherine M. Scardino and members of The Historic Savannah Foundation for their assistance in the preparation of this manuscript.

*2515 Habersham Street
P. L. S.*

MEDICO-ECONOMICS SEMINAR SCHEDULED

The Atlanta Eye Clinic and Atlanta Hospital, 705 Juniper Street, N. E., Atlanta, will hold a two-day Medico-Economics Seminar for practicing physicians, resident physicians, clinic managers and administrators, and other related fields recommended by a physician, beginning on April 18.

This course is designed to cover all aspects of medical management including personnel, accounting, insurance, purchasing, communications, credit and collections, as well as the medical-legal aspects in the

practice of medicine. Faculty consists of 13 specialists who are experienced in medical business administration.

Tuition of \$50 includes luncheons and dinner dance for registrants; \$35 for resident physicians. There is an interesting program provided for the wives of registrants. For information, contact: Mrs. C. Lloyd, Clinic Administrator, Atlanta Eye Clinic, 705 Juniper Street, N.E., Atlanta, Georgia 30308; telephone area 404, 873-2871.

PHYSICIAN LABORATORY CHARGES SUBJECT TO STUDY

John T. Godwin, M.D.

Pathologist, St. Joseph's Infirmary, Atlanta

The cost of medical care is being investigated in various ways. One which is being subjected to study is the cost of laboratory procedures. Laboratories are being questioned concerning the charges made to physicians, patients and hospitals for various procedures.

It is possible that these charges will be matched against the charges made for various laboratory procedures by the physician to the patient.

If the laboratory charges the physician \$3 for a PBI, it has been reported that this is the charge which should be reflected on the patient's bill. The physician may charge a reasonable fee for drawing the blood for the test and his interpretation of the test results, but cannot charge more for the test than is charged by the laboratory.

It has been indicated that the name of the labora-

tory performing the test should be entered on the patient's bill.

It is apparent that the capability for cross checking of charges is available nationwide and is now being used.

It is hoped that physicians will make the changes in their billing systems more in accord with the above information, where necessary, in order to obviate problems after all of the information is in and the computer relinquishes the figures.

Second Annual

COMMITTEE CONCLAVE

July 26-27, 1969

Marriott Motor Hotel Atlanta, Ga.

Such a program is effective in a hospital where the house staff consists of one emergency room physician.

The Value of a Cardiac Resuscitation Program in a Community Hospital

ROBERT W. HUBBELL, M.D. and BENJAMIN B. OKEL, M.D., Decatur

EMERGENCY CARDIAC RESUSCITATION has been made possible by three significant developments during the past two decades. First, the successful conversion of ventricular fibrillation using alternating current shock through the closed chest was demonstrated by Zoll¹ in 1956. Such electrical conversion later became even more effective using high energy, capacitor-stored, direct current shock as advocated by Lown.²

Secondly, a widespread general acceptance of mouth-to-mouth ventilation greatly improved previous methods of emergency artificial respiration.

Thirdly, a safe and effective method of artificial circulation was promoted by Jude et al.³ with their report of external cardiac massage on a large series of patients.

Previous reports³⁻²³ of cardiac resuscitation programs have proved beyond doubt their effectiveness in teaching institutions. The present report intends to show the effectiveness of such a program in a community hospital that has neither interns nor residents, and whose house staff consists of one emergency room physician.

Program at DeKalb General

In June, 1966, a cardiac resuscitation plan (Table I) was promulgated at DeKalb General Hospital, a 224-bed general hospital serving the eastern suburbs of metropolitan Atlanta.

Instruction of hospital personnel in resuscitation techniques is a prerequisite for any successful program of this type. Approximately one year prior to the establishment of the "Blue Alert" program at DeKalb General Hospital, appropriate staff physi-

cians conducted a 14-hour course in coronary nursing care (Table II). The course emphasized basic cardiology, EKG rhythm interpretations, and resuscitation techniques. It has since been repeated at six to nine month intervals, and has been supplemented by training films, in-service conferences, and community medical television.

Results During Two-Year Period

During a two-year period, 110 attempted revivals of 104 patients with cardiac arrest were recorded (Table III). Eighteen of these patients were discharged alive. Thirty-six of 110 "attempts" at resuscitation were considered clinically successful, in that the patients survived more than four hours with autonomous vital functions and without apparent CNS damage. Forty-four of 110 "attempts" were technically successful in that the patients survived long enough to allow dismissal of the resuscitation team.

For the purposes of this report an "attempt" is defined as any or all efforts at resuscitation within a single calendar day. In some cases resuscitative efforts extended over several hours, but for statistical purposes were considered a single attempt. One patient was discharged alive having been defibrillated more than 19 times and another is still alive, having been defibrillated 56 times in a ten hour period.

An analysis of resuscitation results by hospital area (Table IV) reveals that most arrests and best ultimate results occurred on the intensive care unit and the medical floor. The preponderance of acute myocardial infarctions in this series (Table V) accounts for the large number of arrests in these two

areas. Most patients with acute myocardial infarction at DeKalb General Hospital are now initially managed on the intensive care unit.

Discussion

These results compare favorably with previously published experiences with cardiac resuscitation programs in university hospitals (Table VI), and dem-

onstrate the potential life-saving advantages of a cardiac arrest plan in a community hospital. We believe that such a program is not only feasible, but indicated in all hospitals, regardless of type or size. Such a program will, of course, entail the purchase of equipment previously considered a luxury for small hospitals, and will necessitate periodic special training for hospital personnel.

TABLE I
BLUE ALERT

Definition

Blue Alert is an emergency call system to marshal the trained personnel and equipment to a patient who has *suddenly* and *unexpectedly* ceased breathing or has a cardiac arrest.

Contraindications

Terminal patients.

After five minutes have elapsed.

Members of Cardio-Resuscitative Team

- (1) Person who discovers cardiac arrest
- (2) Head nurse of floor
- (3) Emergency Room Nurse
- (4) Emergency Room Physician
- (5) EKG Technician
- (6) PBX Operator
- (7) Central Supply Room Aide
- (8) Nursing Supervisor
- (9) Floor Nurse (team leader)

Role of Person Who Discovers Cardiac Arrest

- (1) Notify nursing station of "cardiac arrest, room" or "Blue Alert room"
- (2) Strike blow to chest over heart area.
- (3) Commence mouth to mouth breathing and external cardiac massage.

Role of Head Floor Nurse

- (1) Notify PBX operator of cardiac arrest and give room number.
- (2) Get emergency cart to patient's bed.
- (3) Place cardiac board under patient's chest or get patient on floor.
- (4) Continue cardiopulmonary resuscitative measures (i.e., external cardiac massage and mouth to mouth breathing or Ambu ventilation).
- (5) Keep records.

Role of Switchboard Operator

- (1) Announce "Blue Alert, #" three times. Pause 30 seconds. Then repeat.
- (2) During night hours, call Emergency Room physician in his room.
- (3) Call Alert to Central Supply Room and Emergency Room.

Role of Emergency Room Nurse

- (1) Get Defibrillator and EKG machine from Emergency Room (room C) to elevator.

Role of Emergency Room Physician

- (1) Immediately go to patient's room and determine status of patient and the necessity for continuing resuscitative measures.
- (2) Defibrillate if indicated.
- (3) Call for Anesthesiologist, Surgeon, or Cardiologist as deemed necessary.

Role of EKG Technician

- (1) Take cardioverter to patient's room and assist as needed.

Role of Central Supply Aide

- (1) Hold elevator for E.R. Nurse. Take resuscitative equipment to floor.

Role of Floor Nurse or Team Leader

- (1) Continue to page and/or cancel page when all members have arrived.
- (2) Take family to waiting room.
- (3) Notify family physician.

Role of Nursing Supervisor

- (1) Fill role of any absent member.
- (2) Assist as needed.

TABLE II
OUTLINE OF CORONARY NURSING
CARE LECTURES

- Introduction
- Anatomy and physiology
- Pulmonary resuscitation
- Cardiac resuscitation
- Cardiac drugs
- Myocardial infarction
- Normal electrocardiogram (2 hours)
- Arrhythmias (4 hours)
- Coronary care electrical equipment
- Quiz and critique

TABLE III
CARDIAC RESUSCITATION RESULTS
DeKalb General Hospital
June 1966 through May 1968

104 patients (65 males, 39 females)	
Technical successes	44/110 attempts
Clinical successes	36/110 attempts
Discharged alive	18

Two by-products of this program deserve comment. First, we have been impressed by an upgrading of medical competence at all levels. The physicians teaching coronary care have become more knowledgeable along with the nurses being instructed. Other physicians are stimulated by erudite nurses to learn new skills. Thus a "non-teaching" hospital becomes a minor institution of learning.

Improved Nurses' Confidence

A second by-product of these cardiac resuscitation-coronary care programs has been a definite increase in the confidence of the nurses involved. Developments in cardiology, as well as in other medical fields, over the past few years have made the nurse a more vital member than ever on the medical team. There can be no doubt that a coronary care nurse administering a defibrillating shock has performed a useful service.

We have encouraged nurses in the administration of countershock and other emergency measures in the absence of a qualified physician. Many of the cardiac arrests on the intensive care unit were handled solely by nursing personnel until the M.D. was available.

TABLE IV
RESUSCITATION RESULTS BY HOSPITAL AREA

Area	Intensive Care Unit	Medical Floor	Emergency Room	Surgical Floor	OB/GYN, GU, Ortho. Flr.	General Floor	Operating Room
Patients	66	25	8	4	3	2	1
Technical success	29	8	3	2	2	0	1
Clinical success	26	7	3	2	2	0	0
Discharged alive	12	3	3	0	0	0	0

TABLE V
RESULTS OF RESUSCITATION BY DIAGNOSIS

Diagnosis	Patients	Technical Success	Clinical Success	Discharged Alive
Acute myocardial infarction	74	34	29	17
Pulmonary emboli	9	3	3	2
Infection*	8	2	2	0
Cerebrovascular accident	5	1	0	0
ASHD (without AMI)	5	2	2	1
Aortic aneurysm (dissecting or ruptured)	4	1	0	0
Trauma†	3	1	0	0
Uremia	2	0	0	0
Miscellaneous‡	4	1	1	0

* Included pneumonia, Listeria infection, pyelonephritis, cholecystitis, septicemia, pancreatitis, diverticulitis, and meningococcemia.
† Includes gun shot wound, head trauma, and multiple fractures.
‡ Includes carcinoma of larynx, WPW syndrome, myxedema, and aortic stenosis.

The AMA²⁴ affirmed such a policy in February, 1968 when it issued a call permitting trained nurses to use monitoring, defibrillation, and resuscitation equipment, and to "institute immediate life-saving corrective measures when a licensed physician is not immediately available to do so." We have found that nurses gain confidence and lose previous fears by being allowed to apply the electrodes in elective atrial defibrillation. We encourage chest auscultation and other diagnostic procedures by nurses.

Approach to Cardiac Arrest

Our general approach to the arrested patient is mnemonically depicted in Table VII. Clearing of the airway takes precedence over all other emergency measures. Laryngeal intubation should not be attempted initially in that it is a time-consuming procedure for the average physician. Also, according to Stock,²⁵ endotracheal intubation may induce ventricular fibrillation because of the hypoxic patient's increased vagal sensitivity. Mouth-to-mouth or mouth-to-S-tube breathing should be performed until a manual bag respirator can be secured in place. External cardiac massage, with the patient on a firm surface, should be done simultaneously with artificial ventilation.

We think it logical to give the arrested patient the benefit of a countershock before making an exact electrocardiographic rhythm diagnosis. Approximately 80 seconds are consumed in applying electrolyte jelly, securing electrode leads and taking an

EKG rhythm strip. If EKG leads are already in place, a short rhythm strip should, of course, be run first.

When the diagnosis of ventricular fibrillation is confirmed by electrocardiogram, transthoracic shock should be administered at a maximal energy setting, i.e. 400 watt-seconds.

Starting Fluids

Fluids should be started as soon as possible through a 16 gauge plastic catheter-type needle inserted in an antecubital or median arm vein. We suggest the use of a 16 gauge, or larger, plastic needle in that it allows easy insertion of a transvenous pacemaker wire* in cases showing second degree or third degree AV block. Kimball and Killip²⁶ have shown this to be a safe and simple technique and advantageous, in that it can be done quickly at the bedside using electrocardiographic guidance in lieu of fluoroscopic control.

Except in cases of frank congestive heart failure, we advise the immediate infusion of at least 90 milliequivalents of sodium bicarbonate to combat metabolic acidosis. For ventricular fibrillation and most other serious arrhythmias, we routinely inject a bolus of 50 to 75 milligrams of lidocaine.

Vasopressor agents should be infused if hypotension persists after the restoration of effective circula-

* Stainless steel multistrand Teflon-insulated platinum probe VSPO, 60 inches, #12569, Davis and Geck Division, American Cyanamide Company, Danburg, Conn.

TABLE VI
PUBLISHED SERIES OF CARDIAC ARREST PROGRAMS

Author	Year	Patients	Technical Successes	Clinical Successes	Discharged
Jude et al. ³	61	118	108		28
Baringer et al. ⁴	61	84	36	23	4
Himmelhoch et al. ⁵	62	65	18		4
Shipman et al. ⁶	62	30	35/49		10
Greenfield ⁷	64	360			10
Ayers and Doyle ⁸	64	48	29	16	8
Kaplan and Knott ⁹	64	100	29	11	6
Jordan et al. ¹⁰	64	100	17	10	3
Lawrence et al. ¹¹	64	123		41	15
Rubin et al. ¹²	64	117		31	17
Smith and Anthonisen ¹³	65	254		80	40
Stemmler ¹⁴	65	103	36		5
Minuck ¹⁵	66	63	25		5
Spanknebel and Kale ¹⁶	66	37	13	8	7
Stephens and Carveth ¹⁷	66	42	11		7
Hansen and Sandoe ¹⁸	66	47		23	16
Roser ¹⁹	67	98	36		15
Neufeld ²⁰	67	93	35		17
Linko et al. ²¹	67	100	49		27
Ho and Quattlebaum ²²	67	119		48	20
Jung et al. ²³	68	100	46	28	20
		(2201)	(523/1200)	(319/1129)	(284/2201)
Total success rate			43.58%	28.25%	12.90%

TABLE VII
KEY STEPS IN TREATING CARDIAC ARREST

- Airway
- Breathing
- Circulation
- Defibrillation
- EKG
- Fluids, NaHCO₃, and anti-arrhythmic agents
- Geck wire or other transvenous pacemaker
- Hypertensive agents (metaraminol or norepinephrine)
- Intensive Care Unit

tion. Metaraminol has, in our experience, been the safest and most useful agent, though norepinephrine is considerably more potent.

Transfer to Intensive Care Unit

Finally, the importance of transferring the salvaged cardiac arrest patient to an intensive care unit cannot be overemphasized. This series and others (Table VI) show that heart action can be restored in a high proportion of patients, but the percentage who ultimately survive is much lower. Close observation and resuscitative measures should be continued while the patient is being moved. Battery-powered equipment can prove invaluable when moving the patient.

Summary

The development and general acceptance of electrical defibrillation, external cardiac massage, and mouth-to-mouth respiration during the past two decades have made possible effective cardiac resuscitation programs. The effectiveness of such a program in a non-teaching community hospital is reviewed. Over a two-year period emergency resuscitation was attempted on 104 patients. Eighteen survived to be discharged alive. More than one third were clinically successful, in that the patient survived more than four hours without apparent CNS damage. These results compare favorable with published series (average clinical success rate 28 per cent; average discharged-alive rate 13 per cent) and are perhaps attributable to conscientious training of nurses in coronary care.

ACKNOWLEDGEMENT

We appreciate the invaluable assistance of the DeKalb General Hospital nursing staff and EKG technicians in conducting this program.

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The objective of this report is to show the practicability of mass screening of newborn infants before their hospital discharge.

The Results of PKU Screening in the Georgia Public Health Laboratories January 1967—June 1968

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THE GEORGIA DEPARTMENT of Public Health laboratory began testing for phenylketonuria (PKU) in December 1962 as part of a nationwide study of a phenylalanine procedure known as the Guthrie test. This program was under the direction of Dr. Robert Guthrie,⁶ University of Buffalo, and was largely supported by a grant from the Children's Bureau, U. S. Department of Health, Education and Welfare.

Georgia's first phenylketonuric newborn infant was detected the following spring. During the period of this special study, sufficient interest was expressed to assure continuation of the service. In 1966 a law requiring PKU testing of newborn infants was passed by the Georgia General Assembly.

Follow-up Procedure Outlined

The number of Guthrie tests performed by the Central Laboratory increased from 9,011 in 1963 to 39,044 in 1967. With this increase in volume came an increase in the number of Guthrie test results at the screening level of 4 mg or more of phenylalanine/100 ml of blood. In January 1967 a procedure for the follow-up of screening positives was outlined by a special committee representing the Georgia Department of Public Health, the Emory University School of Medicine, the Medical College of Georgia, and the Georgia Academy of Pediatrics' Committee on the Handicapped Child.

During the 18 months of this follow-up program, an amino acid screening chromatographic method³

was performed whenever possible on infants with a positive Guthrie test result. In addition to confirming an abnormally high concentration of phenylalanine, the chromatograms have been of value in detecting elevations of blood tyrosine, a condition that is not consistent with the laboratory diagnosis of PKU.^{4, 9}

This paper will present and discuss the results of the screening examinations for this period, and give a summary of PKU detection since the beginning of the program.

Materials and Methods

The State laboratories perform the Guthrie test essentially as described by Guthrie,⁶ substituting commercially available products.

To insure that adequate records are maintained, an identification form is attached to the filter paper strip used for blood collection. Circles measuring $\frac{3}{8}$ inch in diameter are printed on both sides of the filter paper to assist with the collection of a sufficient amount of blood: a spot which should measure at least $\frac{1}{4}$ inch in diameter on both sides of the filter paper.

The medium (Bacto PKU Test Agar, Difco #0980-01) is prepared according to the manufacturer's directions and is seeded with Bacto Subtilis Spore Suspension Number 2 (Difco #0981-84). The test specimens and controls (BBL PKU Control Disc Strip #08-700), which consist of known concentrations of phenylalanine, are autoclaved at 15 pounds pressure, 121° C for three minutes. The steam is then exhausted for one minute to allow the specimens and controls to dry. Controls are run in parallel on each tray. The tests are incubated for 17 hours.

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Determining Range of Phenylalanine

The range of phenylalanine is determined by comparing the reaction of the patient unknowns with that of the controls. All specimens reading less than the 4 mg/100 ml controls are reported as "within normal limits." Specimens reading 4 mg/100 ml or greater are reported as "above normal limits" and an estimated range of phenylalanine concentration is given.

The amino acid screening paper chromatographic technique is performed as described by Efron³ with the following exceptions:

- (1) Proline color development is obtained by heating the chromatogram at 100° C for ten minutes;
- (2) Hydroxyproline color development is obtained by spraying the chromatogram with Ehrlich's reagent (2 grams of *p*-dimethylaminobenzaldehyde dissolved in 10 ml of hydrochloric acid and diluted to 100 ml with water);
- (3) Citrulline color development is hastened by leaving the chromatogram at minus 20° C for thirty minutes.

Results

The results of screening tests done on the initial specimen received are given in Table I. Of 57,494 infants tested, 398 (0.7 per cent) specimens yielded positive Guthrie results. About one fourth of the positive specimens contained insufficient blood for chromatographic studies. Chromatograms of the remaining 307 showed 100 (32.6 per cent) with a marked elevation of blood tyrosine.

A second specimen is requested on each patient whose initial Guthrie test gives a reading of 4 mg of phenylalanine or greater in 100 ml of blood. A coded outfit is sent to the physician for collecting the repeat specimen to assure its recognition as a second specimen. The number of cases that had follow-up studies may be seen in Table II. At least one follow-up specimen was submitted on 293 (73.6 per

TABLE I		
RESULTS OF INITIAL SCREENING TESTS DONE ON NEWBORN INFANTS, JANUARY 1967 THROUGH JUNE 1968		
	Number	Per Cent
Guthrie Test Results		
Phenylalanine < 4 mg/100 ml	57,096	99.3
Phenylalanine ≥ 4 mg/100 ml	398	0.7
Total tests performed	57,494	100.0
Chromatographic Results		
Tyrosine < 10 mg/100 ml	207	67.4
Tyrosine ≥ 10 mg/100 ml	100	32.6
Total tested	307	100.0

TABLE II
FOLLOW-UP OF CASES WITH INITIAL ELEVATED GUTHRIE TEST RESULTS

	Number	Per Cent
Follow-up	293	73.6
No follow-up	105	26.4
Total cases	398	100.0

cent) of the infants with an initial positive screening test result.

Table III gives the results for the follow-up specimens submitted from the 293 infants with a previous elevated Guthrie test result. Some individuals have had several follow-up specimens, but the test results are not broken down into such categories. A total of 412 specimens were received, 68.9 per cent (284) of which were within normal limits. Chromatographic studies on 133 of these specimens showed marked elevation of tyrosine in 27 (20.3 per cent).

Obtaining Reliable Results

Reliable test results depend upon the blood specimen being at least ¼ inch in diameter with complete saturation of the filter paper by the infant's blood. All specimens (no matter how scant the blood) are tested on the assumption that one-half or one-fourth of the necessary blood from a phenylketonuric infant would give results at least at the screening level. Test results less than 4 mg phenylalanine/100 ml from such specimens are reported as "no test, quantity insufficient." When any elevation is obtained, it is reported.

Inhibition of Test Organism

Since the Guthrie test is a bioassay procedure, it is not surprising that inhibition of the test organism is occasionally observed. Inhibition has occurred with specimens from infants receiving antibiotics, but there have been instances when unexplained inhibition occurs in the absence of antibiotic therapy. Interference with the test organism's growth could mask an elevated phenylalanine concentration. Partington¹⁸ also encountered inhibition with six blood samples out of 6,348 tests performed. These samples were from newborn infants, and only two were receiving antibiotics at the time the samples were collected.

A breakdown of specimens that were either insufficient in quantity or gave inhibition is presented in Table IV.

Rate of Detection

Since the beginning of the program in 1962, 15 cases of PKU have been detected in about 138,000

newborn infants tested. It is of interest to compare Georgia's rate with that of four other States. Massachusetts reports 14 cases in about 135,000 newborns tested by January 1964;¹⁵ Ohio reports 13 cases out of 106,255 newborns tested by September 1965;² and Oregon reports an incidence of one case in 9,-000-10,000 tested.¹⁹ The rate of detection in North Carolina was three cases per 68,993 newborns for 1966¹⁶ and three cases per 82,801 newborns for 1967.¹⁷

During the period from January 1967 through June 1968 only two cases of PKU were detected among the 57,494 newborn infants tested by the State laboratories. Confirmatory testing was done in the central State laboratory on two additional cases identified by private laboratories. During one week of July 1968 two infants with PKU were detected.

Adult Cases of PKU

In older persons 13 cases of PKU were detected, including an adult female with three living children. Specimens are frequently submitted on family members of phenylketonuric cases or on mentally retarded individuals. From this group, a total of 48 cases of PKU have been identified since the beginning of this program.

With such a low incidence of PKU detection in the newborn group with an initial positive Guthrie test, the screening level of 4 mg/100 ml might seem overly cautious. MacCready¹⁵ reported that a child with an initial test result of 4 mg/100 ml later was diagnosed as having PKU. The initial test readings on the first and the most recent phenylketonuric infants found in Georgia were 6 mg/100 ml of blood.

Efron,⁴ Hsia,⁷⁻⁹ LaDu¹¹ and Light¹⁴ note that an elevation of phenylalanine may be associated with high blood concentrations of tyrosine. Our screening level does appear to detect infants with a defect in the tyrosine-oxidizing system, because chromatographic studies show that almost one-third of the in-

TABLE IV
SUITABILITY OF TEST SPECIMENS RECEIVED
ON NEWBORN INFANTS, JULY 1967
THROUGH JUNE 1968

	Number	Per Cent
Suitable for testing	39,368	97.4
Quantity insufficient	927	2.3
Inhibition	132	0.3
Total received	40,427	100.0

fants with an initial positive Guthrie test result have blood tyrosine concentrations of 10 mg/100 ml or greater, a value far exceeding normal.⁵ However, the chromatograms done on the blood of the few newborn phenylketonuric infants have never shown an elevation of any amino acid other than phenylalanine.

Hsia⁸ shows supporting data that a slight elevation of phenylalanine almost always accompanies an elevation of tyrosine, especially in low birth weight infants. He suggests that those infants with initial elevations of phenylalanine, who do not have PKU, are heterozygotes for PKU or have an excess of tyrosine. However, he found a mean of 2.35 mg of phenylalanine/100 ml for 87 observations made on 34 siblings of phenylketonuric patients. The mean for 4,-000 normal infants was 2.08 mg/100 ml.⁹ LaDu¹¹ reports that a "number" of young infants have tyrosine values between 16 and 28 mg/100 ml. The defect in the enzymatic activity that leads to an elevated blood tyrosine is discussed by Hsia,^{7, 9} La Du,¹¹ and Light.¹⁴

High Blood Tyrosine Concentration

A defect in the tyrosine-oxidizing system of premature infants on an ascorbic acid free, high protein diet was first noted by Levine¹² who showed that ascorbic acid corrects this condition.¹³ Subsequent work has shown that the liver of an adult has 10 to 30 times the ability to oxidize tyrosine as does the liver of a premature infant.¹⁰ More recently, data has been presented by Light¹⁴ showing that a high blood tyrosine concentration can be treated or prevented with a single 100 mg dose of ascorbic acid. Observations concerning elevated blood tyrosine concentrations are given by Avery.¹

No attempt has been made to break down our data according to the birth weight of the infant, his age, or race. Knowledge of the findings of these other groups has been helpful in understanding the results of our screening program.

Summary

The results of PKU screening testing on newborn infants from January 1967 through June 1968 are given.

TABLE III
RESULTS OF FOLLOW-UP TESTING ON
SPECIMENS FROM INFANTS WITH PREVIOUS
ELEVATED GUTHRIE TEST RESULTS,
JANUARY 1967 THROUGH JUNE 1968

	Number	Per Cent
Guthrie Test Results		
Phenylalanine < 4 mg/100 ml	284	68.9
Phenylalanine ≥ 4 mg/100 ml	128	31.1
Total specimens received	412	100.0
Screening Chromatograms		
Tyrosine < 10 mg/100 ml	106	79.7
Tyrosine ≥ 10 mg/100 ml	27	20.3
Total specimens tested	133	100.0

During the 18-month period the Guthrie test was performed on 57,494 newborn infants, and 398 (0.7 per cent) showed 4 mg of phenylalanine/100 ml or exceeded this screening level. A screening chromatographic examination detected 10 mg tyrosine/100 ml or greater in 100 (32.6 per cent) of 307 infants from this group of positives.

Follow-up testing was done on 293 (73.6 per cent) of the infants with an initial screening positive test result. Of the 412 specimens tested from this group, only 128 (31.1 per cent) showed an elevated phenylalanine level. Chromatographic studies were done on 133 of these specimens, and 27 (20.3 per cent) had blood tyrosine levels of 10 mg/100 ml or greater.

During this 18-month period the State laboratories detected two cases of PKU in newborn infants. Based on confirmatory testing in the State health department laboratories, four phenylketonuric infants were detected in Georgia—a rate of one in 14,000. Thirteen cases of PKU, including a mother of three living children, were detected in older persons.

Since the inception of the PKU detection program the State laboratories have identified fifteen cases of PKU in about 138,000 newborns tested, a rate of one in 9,200. A total of 48 phenylketonuric patients have been detected in older persons.

During FY 1968 specimens were received from 40,427 newborn infants; 39,368 (97.4 per cent) of the specimens were satisfactory for testing. Inhibition occurred during the performance of the screening bioassay on 132 (0.3 per cent) of the specimens. The quantity of blood was not sufficient for reliable testing of 927 (2.3 per cent) of the specimens.

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SEMINAR ANNOUNCED ON PEDIATRIC SURGERY

The Division of Pediatric Surgery of the Department of Surgery, Medical College of Alabama, will present a two-day pediatric surgery seminar on April 11-12, 1969 in Birmingham, Alabama.

The internationally-renowned physician, Dr. Robert E. Gross will serve as guest lecturer during the seminar. Dr. Gross is William E. Ladd Professor of Child Surgery at the Harvard School of Medicine, Boston, Mass., and chief of cardiovascular surgery at Children's Hospital Medical Center, Boston.

Physicians are cordially invited to attend this seminar. There is no registration fee. If additional information is needed, contact Dr. Luther A. Longino, professor and director, Division of Pediatric Surgery, Department of Surgery, Medical College of Alabama, 1919 7th Avenue South, Birmingham, Alabama 35233.

Survivals for five and ten years may have no bearing on the final outcome of patients with thyroid cancer.

Thyroid Carcinoma: A Survey of 133 Consecutive Cases

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THYROID CARCINOMA is a particularly interesting disease due to the wide variety of histologic appearances and virtually unpredictable clinical course. Although some patients die of disease within a few years of diagnosis, some survive for many years and during the course of their disease may see several physicians in different locations which makes complete follow-up often difficult.

This study was undertaken in order to analyze 133 patients with thyroid cancer seen at Emory University Clinic from 1937 to 1962 with regard to histologic type of tumor, age, sex and survival. The time interval was chosen in order that a minimum five-year follow-up would be available. A comparison between our regional experience with thyroid carcinoma and other series should be of interest because 79 of our patients have been followed for ten years or more.

Material

The clinic records of all patients seen from 1937 to 1962 with a diagnosis of thyroid carcinoma were reviewed. Those patients seen in consultation, but not followed by the Emory University Clinic, were excluded. Patients were also excluded when insufficient pathologic material was available for review.

Analysis of Cases

The tumors were classified into six types: (1) predominantly papillary; (2) mixed papillary and follicular; (3) pure follicular; (4) Hurthle cell; (5)

anaplastic (spindle and giant cell); and (6) medullary carcinoma.

The division of the category papillary carcinoma into predominantly papillary carcinoma and mixed papillary and follicular carcinoma, as suggested by Underwood et al.,⁴ was found useful since this best describes the most frequent histological types of carcinomas of the thyroid gland. The diagnosis of Hurthle cell carcinoma is based on capsule invasion by the tumor in both reported cases. The two examples of medullary carcinoma histologically show a tumor composed of small pleomorphic cells within an amyloid stroma.

Table I shows the number and per cent of the various types of tumors. The relative frequency of the different types of tumors coincides with that which is generally accepted today. Papillary and mixed papillary and follicular carcinoma constituted about 62 per cent, follicular carcinoma about 29 per cent. The overall female to male ratio was 2.7:1.

Papillary Carcinoma

Of the 55 cases of papillary carcinoma, 38 cases were in females and 17 in males. The average age in females was 37 (age range 18-69), and in males 45 (age range 11-83). The average duration of

TABLE I

Histologic Type	Number of Patients	Per Cent
Papillary	55	41.4
Mixed papillary and follicular ...	28	21.0
Follicular	39	29.3
Hurthle Cell	2	1.5
Anaplastic	7	5.3
Medullary	2	1.5
Total	133	100.0

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symptoms prior to initial therapy was 23 months. The onset of symptoms was judged from the patient's recognition of a mass in the neck, or the thyroid, or other symptoms related to the disease process. Table II gives the stage of disease at the time of diagnosis in patients with papillary carcinoma.

TABLE II STAGE OF DISEASE AT TIME OF DIAGNOSIS PAPILLARY CARCINOMA	
Local	24
Adjacent extension	4
Regional metastases	22
Distant metastases	5

Deaths have occurred in 13 patients. Pertinent data on the patients dying after the diagnosis of papillary carcinoma was made are given in Table III.

It is readily apparent that most patients dying of or with papillary carcinoma had relatively advanced disease at the time of diagnosis. All but one had regional or distant metastases at the time of initial therapy. Three patients died from other causes and were clinically free of tumor. The average survival of the patients dying from thyroid carcinoma or with thyroid carcinoma is 82.9 months.

Forty patients are living and free of disease. The average survival of these patients is 136.6 months.

Two patients have recurrence of their disease in the neck region after surviving 268 months and 156 months.

Mixed Papillary and Follicular

This group of 28 patients consists of five males with an average age of 29 (age range 10-77), and 23 females with an average age of 40 (age range 10-62). The stage of disease at the time of diagnosis is given in Table IV. The average duration of symptoms was 29 months. There has been one death in the mixed carcinoma category in a 62-year-old female who was treated with a thyroidectomy for local disease. She died after surviving eight months with recurrent disease present. Twenty-one patients have survived an average of 152 months with no evidence of disease. Six patients have recurrent disease and their average survival at the present time is 121 months.

Follicular Carcinoma

Thirty-nine patients had follicular carcinoma. There were eight males (age range 6-64), and 31 females (age range 12-72). The average duration of symptoms prior to the diagnosis of follicular carcinoma was 40 months. The stage of disease at the time of diagnosis is given in Table V. The average survival of patients dying with follicular carcinoma present or as the cause of death was 69.7 months. Table VI summarizes the clinical data on the pa-

TABLE III DEATHS IN PATIENTS WITH PAPILLARY CARCINOMA					
Case	Age at Diagnosis	Stage of Disease at Diagnosis	Treatment	Survival Months	Cause of Death
138	75	Distant metastases	RAI	13	Thyroid carcinoma present or cause
100	72	Adjacent extension	Surgery and radiation	117	Other. No evidence of disease at last contact
95	56	Local disease	Surgery	92	Other. No evidence of disease at last contact
88	62	Local disease	Surgery	0	Postoperative aspiration and pneumonia
78	67	Regional metastases	Radiation and surgery	6	Thyroid carcinoma present or cause
54	83	Distant metastases	Radiation	11	Thyroid carcinoma present or cause
48	48	Distant metastases	RAI	13	Thyroid carcinoma present or cause
31	45	Regional metastases	Surgery and RAI	146	Thyroid carcinoma present or cause
33	60	Distant metastases	Surgery and RAI	156	Thyroid carcinoma present or cause
34	67	Regional metastases	Surgery	5	Thyroid carcinoma present or cause
13	18	Regional metastases	Surgery and radiation	250	Thyroid carcinoma present or cause
10	68	Local disease	Radiation	32	Thyroid carcinoma present or cause
9	48	Distant metastases	Surgery and radiation	197	Thyroid carcinoma present or cause

TABLE IV

STAGE OF DISEASE AT TIME OF DIAGNOSIS
MIXED PAPILLARY AND FOLLICULAR
CARCINOMA

Local	15
Adjacent extension	0
Regional extension	11
Distant metastases	2

TABLE V

STAGE OF DISEASE AT TIME OF DIAGNOSIS
FOLLICULAR CARCINOMA

Local	25
Adjacent extension	1
Regional metastases	9
Distant metastases	4

tients with follicular carcinoma that are now deceased. Twenty-four patients are living with no evidence of disease and the average survival is 136 months. Two patients have had recurrence of their disease in the neck at 83 and 248 months.

Hurthle Cell Carcinoma

Two patients in this series had Hurthle cell tumors. The patients were 18 and 22 years of age at the time of diagnosis and had symptoms for one and

seven months respectively. The disease was confined to the thyroid and both were treated with a hemithyroidectomy. They remain free of disease at 73 and 129 months.

Anaplastic Carcinoma

Seven patients were diagnosed as having spindle cell and giant cell anaplastic carcinoma. There were four males and three females. Table VII lists age of diagnosis, stage of disease, therapy, and months of survival. The average duration of symptoms before diagnosis was two months. Five of the seven patients were dead within six months and two survived 61 and 68 months.

Medullary Carcinoma

Two patients, both males, had medullary (solid) carcinoma. They were 38 and 48 years of age with symptoms for one and 96 months respectively. Both patients were treated surgically with removal of the thyroid gland and a radical neck dissection. Both died with thyroid carcinoma present or the cause of death. They survived 162 and 141 months respectively.

Childhood Thyroid Carcinoma

Ten of the above 133 patients were children under 15 years of age. These patients have previously been included in the series of children followed by Winship and Rosvoll.⁵ There were six males and

TABLE VI
DEATHS IN PATIENTS WITH FOLLICULAR CARCINOMA

Case	Age at Diagnosis	Stage of Disease at Diagnosis	Treatment	Survival Months	Cause of Death
7	69	Distant metastases	Surgery, RAI	142	Thyroid carcinoma present or cause
8	30	Local	Surgery, RAI, radiation	85	Thyroid carcinoma present or cause
24	50	Local	Surgery, RAI	26	Thyroid carcinoma present or cause
29	63	Local	Surgery, RAI	108	Thyroid carcinoma present or cause
36	40	Local	Surgery	63	Other. No evidence of disease at last contact
44	68	Distant metastases	RAI	17	Thyroid carcinoma present or cause
49	62	Distant metastases	Surgery, RAI	216	Thyroid carcinoma present or cause
51	68	Local	Surgery	46	Thyroid carcinoma present or cause
67	64	Local	Surgery, radiation	59	Thyroid carcinoma present or cause
70	40	Regional metastases	Surgery	66	Thyroid carcinoma present or cause
71	55	Distant metastases	Surgery, RAI	61	Thyroid carcinoma present or cause
79	51	Adjacent extension	Surgery, RAI	62	Thyroid carcinoma present or cause
98	50	Local	Surgery	0	Bacteremia, incidental finding of carcinoma of thyroid at autopsy

TABLE VII
PATIENTS DIAGNOSED AS ANAPLASTIC CARCINOMA

Case	Age at Diagnosis	Stage of Disease at Diagnosis	Treatment	Survival Months	Cause of Death
20	58	Local	Surgery	61	Other. No evidence of disease at last contact
40	59	Distant metastases	Surgery and radiation, RAI	2	Thyroid carcinoma present or cause
47	59	Adjacent extension	Radiation	6	Thyroid carcinoma present or cause
81	70	Distant metastases	Radiation	2	Thyroid carcinoma present or cause
112	57	Local	Radiation and surgery, RAI	5	Thyroid carcinoma present or cause
120	85	Local	Radiation, surgery	68	Other. No evidence of disease at last contact
131	81	Distant metastases	Surgery	2	Thyroid carcinoma present or cause

four females. Six patients gave a past history of irradiation, four to the thymus and two to the tonsils and adenoids. There were four children with follicular carcinoma, five mixed papillary and follicular carcinoma, and one papillary carcinoma. The average survival at their last follow-up was 142 months. Two patients are known to have distant metastases and eight have no evidence of disease.

Discussion

The five-year and ten-year survivals are given in Table VIII. These survival rates are based on patients surviving a given length of time when a selected group of patients is considered. Patients lost to follow-up, and those dying of other cause without neoplastic disease are not considered in calculating these survival rates. These figures compare to similar results obtained in the series of 100 cases of thyroid carcinoma followed five years by France et al.³ If one divided the thyroid carcinoma into papillary carcinoma, follicular carcinoma and undifferentiated thyroid carcinomas as classified by James,³ then we have a larger percentage of five-year and ten-year

survivals for papillary and follicular carcinoma than his combined series.

Significant Survival Rates

The deaths from papillary carcinoma occurred most frequently in patients who were more than 40 years of age at the time of diagnosis, and the prognosis does not appear to be as good as that of mixed carcinomas. The survival figures for mixed papillary and follicular carcinoma appear to justify the separation of this group of thyroid carcinomas. However, since six of 27 surviving patients in this group are living with recurrent disease, it appears that the survival rates at 15 or 20 years would be of greater significance in evaluating a real difference in the prognosis of the papillary and mixed tumors.

The patients with follicular carcinoma have a more variable course and a longer duration of symptoms, as has been observed in Woolner's series.⁶ The survival rates are significantly lower than the papillary carcinoma or the mixed papillary and follicular carcinoma.

Two of seven patients with anaplastic carcinoma lived longer than six months. Survivals longer than one year, and up to 14 years, occurred in 22 per cent of the series by Woolner et al.,⁶ which included 130 patients with anaplastic carcinoma.

Medullary carcinoma and Hurthle cell tumor comprise only three percent of this series. Three of the four patients survived ten years, but both patients with medullary carcinoma ultimately died with carcinoma present, after surviving more than ten years. This again emphasized that survivals for five and ten years may have no bearing on the final outcome of patients with thyroid cancer.

Childhood carcinoma accounted for ten cases with in this series. The high incidence of irradiation (60 per cent) to the thymus or neck region in childhood

TABLE VIII
SURVIVAL RATES

Histologic Type	No. of Cases Evaluated	5 Years Per Cent	No. of Cases Evaluated	10 Years Per Cent
Papillary	50	84	33	84
Mixed papillary and follicular	28	96	16	94
Follicular	33	81	25	64
Hurthle cell	2	100	1	100
Anaplastic	7	28	2	0
Medullary	2	100	2	100

carcinoma, as noted previously,^{2, 5} is well documented in this series.

The difficulty in complete follow-up of patients with thyroid carcinoma is emphasized by the fact that an autopsy was done on only seven of the 34 patients in this series who have died.

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NEW YORK CITY IS SITE OF AMA'S CONVENTION

New York City is the site of the American Medical Association's 118th Annual Convention, July 13 through 17.

A total registration of 60,000 is predicted for the 1969 convention, including some 22,500 physicians. Medical students, nurses and other members of allied medical professions, industrial exhibitors, and guests make up the rest of the registrants.

Scientific Sessions

Four general scientific sessions are planned:

- Human Sexuality
- Physical Fitness and Aging
- Impact of Medical Education on Patient Care
- Chronic Pulmonary Insufficiency and Air Pollution Problems

Special Topics Program

Each of 22 scientific sections also will present a program. The 23rd section—on special topics—plans six sessions:

- Drug Utilization (in cooperation with AMA's Council on Drugs)
- Mental Health Dynamics in the Pre-School Child (in cooperation with AMA's Council on Mental Health)
- Disaster Planning for Aviation Accidents (in cooperation with AMA's Committee on Disaster Medical Care)
- Neurological Surgery
- Nuclear Medicine
- Plastic and Maxillofacial Surgery

The May 26 issue of *The Journal of the American Medical Association* will list the entire scientific program.

AMA BOOKLET GIVES GUIDELINES FOR PATIENTS

Can your patients recognize a real emergency? Or is, as they see it, every bump or bruise, ache or pain an emergency?

The AMA's new pamphlet, "When to Call or See Your Physician," establishes guidelines helpful to patients determining when to seek medical aid.

The pamphlet lists four indications which call for immediate medical attention—severity, persistence, repetition and doubt. Any one of the four is sufficient; two or more increase the urgency.

In addition, the pamphlet cites circumstances which indicate that a doctor's help is needed. Some of the common conditions described are blackouts, breathlessness, dizziness, fatigue, headaches, indigestion, itching, sores and swelling.

Single review copies may be obtained from the AMA's Health Education Department. Quantity orders are available from the Order Department at 15¢ each; 12¢ each for 100-499; 10¢ each for 500-999; 8¢ each for 1000 or more.

PLAN TO ATTEND

115th ANNUAL SESSION—MEDICAL ASSOCIATION OF GEORGIA

May 4-7, 1969

Savannah Inn and Country Club—Savannah, Georgia

Fetal Malformations of Amniogenic Origin

RICHARD TORPIN, M.D., *Augusta,** and ROMAN R. KNOBLICH, M.D., *Flint, Michigan†*

ALTHOUGH THE PLACENTA was not critically examined in either of the two cases reported here, the rather typical features of the fetal malformities are characteristic of this origin.

The first case described here appeared in the family of one of us (R.R.K.). The wife, and mother of three normal children, at 3 months of pregnancy, while horseback riding had a sudden sharp pain in the lower abdominal region. This lasted for a few hours but there was no fluid or blood loss.

No further trouble was experienced and the pregnancy continued until possibly a few weeks prior to the term date when the membranes ruptured spontaneously. This was associated with rather heavy, painless vaginal bleeding. A placentagram showed that the placenta was in the left anterior uterine fundus.

Minor Malformations

This bleeding subsided, and two days later she spontaneously was delivered of a slightly immature male infant weighing 4 lbs. 15 oz. which appeared in good condition, but with minor malformations. Encircling the right ankle a constriction band was noticed. The foot below was swollen and showed a mild metatarsus varus. The left foot had a mild form of clubfoot. The skin of the lower and upper extremities revealed multiple linear, well-healed scars. The alert infant became somewhat jaundiced, but the bilirubin, after a rise, dropped without exchange transfusion. There were no other obvious or detected malformities except that the infant was born with prematurely erupted deciduous, mandibular, central incisors. These were extracted three days later.

The ankle constriction was treated by immediate Z-plasty operation and the swelling subsided. The foot malpositions were corrected by orthopedic casts. Figure 1 was drawn from photographs made when the child was three years old.

The mother, 35 years of age, had given birth to two boys and a girl, then four, three, and two years old. The only disorder had been a tendency to pyc-

litis. The three infants at birth had weighed 7 lbs. 2 oz., 5 lbs. 13 oz., and 6 lbs. 3 oz., respectively. One year prior to this described pregnancy, she had had a spontaneous abortion at three or four months of gestation.

Second Case

An obstetrician friend of one of us (R.R.K.) relayed the following experience. One of his patients expressed concern over the possibility of malformation in her (first) unborn fetus. The reason was that her father, since birth, lacked the left hand and lower forearm. The stump was well-healed and there was, in addition, a slight shortening of the right index distal phalanx. This stump had a thickened remnant of a nail as well as a constriction immediately proximal. These were shown in photographs from which Figure 2 was drawn.



FIGURE 1

Copied from photograph, this illustration shows the fine scars encircling the left leg. Above the right ankle is the scar of the Z-plasty operation.

* Medical College of Georgia, Department of Obstetrics and Gynecology, Augusta, Georgia.

† Hurley Hospital, Department of Pathology, Flint, Michigan.

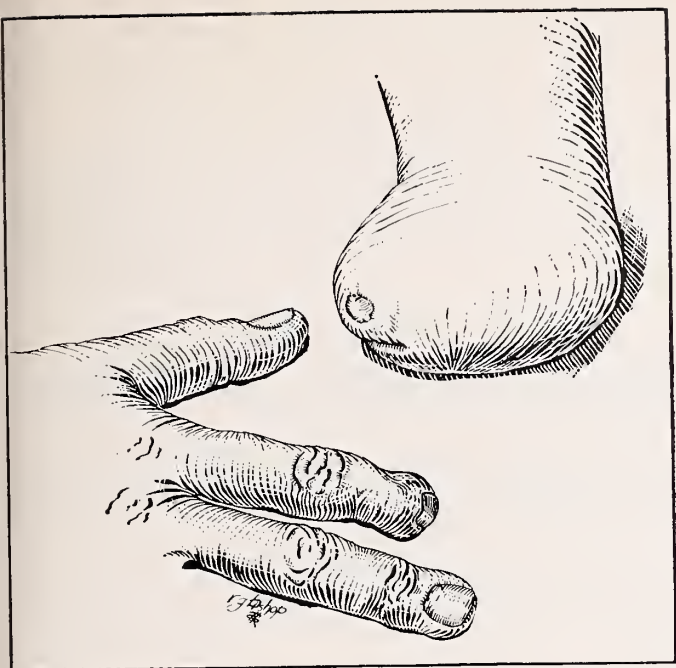


FIGURE 2

Showing the left forearm stump and the amputation, through the nail, of the distal phalanx of the right index finger, as well as a proximal constriction on the same phalanx.

An interesting sidelight, very possibly true, is that his mother attributed it to the fact that she was driving a truck during her pregnancy. Probably in those days truck driving was much more bumpy than at the present time.

Comment

These lesions in the newborn are so rare (about one in 5,000 deliveries) that few physicians become expert in examining the placenta in respect to their possibility. Such an examination of the fresh placenta, however, should be sufficient to prognosticate in the unseen newborn the presence or absence of such lesions.

If the amnion is intact throughout the fetal sac, such fetal lesions are impossible. On the other hand, if the amnion is not intact, having been ruptured sometime prior to labor, in the gestation and without injury to the overlying chorion, very few fetuses escape injury. From the state of the long ruptured and displaced amnion one may foretell, quite well, the type of fetal lesion, as well as estimation of the stage in gestation that the rupture took place. In a very few recorded cases, however, the fetus has escaped injury. These few, and the hypothetical reasons why they escaped, have been summarized from the literature.¹

Reconstruction of the probable course of events in respect to Case 1 may be made as follows. The amnion presumably ruptured without injury to the chorion at the time of the horseback trauma. The fetus and amniotic fluid emerged into the chorionic cavity. The amniotic fluid was absorbed by the am-

nion-denuded chorion, thus putting pressure on the fetal distal extremities inducing clubfoot.

Chorion Thickens and Toughens

Subsequently, the chorion became thicker and tougher developing a mesoblastic membrane capable of retaining the reforming amniotic fluid. The active fetus then had to contend with free-floating amnion strands which encircled the limbs, lightly in all areas except one above the right ankle. With the rapid growth of the fetus, this constriction became tighter, eventually retarding the blood and lymph flow from the foot which then became edematous, as was found at birth.

Of course, the correct surgical procedure, as was carried out, was the Z-plasty operation. Thus, the zigzag new scar may unfold with the future enlargement of the limb.

Since one-third of the recorded cases were reported to have had clubbing of the feet, it is reasonable to suspect the crowding at this stage may have produced it. This is in line with the reasoning of Parker and Shattock, 1884,² and of Denis Browne, 1936.³

Explanation of Nail Remnant

In respect to the horny, thickened and incurved remnant of the nail of the right index finger of Case 2, such a situation frequently has been described in the rather voluminous pertinent literature. It seems that the tips of the fingers and toes, exhibiting the most sweeping motion of any external part of the fetal body, are subject to entwining by extraneous strands. Thus the extreme tips of the digits distal to the nail-bed become encircled and amputated. These separated fragments have been found still attached to the amnion strings. An interesting observation is that the thumb, which is frequently held flexed in the palm of the hand is much less vulnerable than the big toe.

The first recorded case of an amputated forearm with the separated part found in the fetal membranes was by Chaussier of Paris in 1812.⁴ Since then, about ten such amputated arms or legs have been recovered and reported.

The history of each of these two instances here recorded gives a hint at least of some degree of trauma as a factor in the etiology.

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Some of these hearts may be susceptible to bacterial endocarditis or arrhythmias.

The Late Apical Systolic Murmur

JOSEPH W. LINHART, M.D.,* *Miami Beach, Florida*

DURING THE PAST FIVE YEARS, evidence has accumulated that an apical systolic murmur confined to the latter part of systole, unrelated to coronary artery disease, is not necessarily benign or functional in nature. The late systolic murmur was initially related to extracardiac structures, such as the pericardium. Since these late systolic murmurs were frequently associated with mid systolic clicks, and since pericardial adhesions were seen at autopsy in some of the latter patients, the belief in a benign extracardiac origin was a natural assumption.

However, a number of observers have recently presented evidence that the late systolic apical murmur, and even the mid systolic clicks, may (1) arise from the mitral valve and its supporting structures; (2) be associated with a characteristic deformity of the mitral valve; (3) be associated with mild to moderate late mitral regurgitation; and (4) not necessarily be benign in clinical course.

Clinical Characteristics

Patients with late apical systolic murmurs and late mitral regurgitation have generally been young or middle-aged adults with a predominance, in our experience, of females between 20-40 years of age. Occasionally, a history of rheumatic fever is elicited, but generally no definite etiologic factor can be ascertained for the murmur. Oftentimes, the murmur was first noted in childhood and this, plus the occurrence in more than one family member, suggests a congenital and familial incidence in some patients.

Most patients are asymptomatic, and were referred for study only because a murmur was present

on routine examination. Some may have palpitations, easy fatigability and breathlessness on heavy exertion. Most functionally are class I or II (N.Y. Heart Assoc. Classification).

Apex Phonocardiography

No significant vibrations are present in early systole. The murmurs occupy the last one-half or two-thirds of systole, and tend to be crescendo in character, ending with the aortic closure sound. The murmur may be initiated by one or more systolic clicking sounds. Mostly, the murmurs would be graded 2-3/6 and there is little radiation of the sound from the apex.

The late systolic murmur responds to drugs in a fashion similar to the typical holosystolic murmur of mitral regurgitation. With phenylephrine, which raises blood pressure and LV pressure, there is an intensification of the holo—and late systolic murmurs of mitral insufficiency. When amyl nitrate is inhaled and the systemic arterial pressure decreases, these murmurs decrease in intensity.

Electrocardiograms

In general, the electrocardiogram is normal, although occasionally the criteria for left ventricular hypertrophy may be present. Some cardiologists have described significant electrocardiographic changes in association with late systolic clicks and murmurs. These generally consisted of abnormal T waves and S-T segments in leads 2, 3 and AVF. In addition, ventricular extrasystoles and paroxysmal tachycardia were seen.

Chest Roentgenography

Generally, no significant abnormalities are detected by roentgenography. In a few patients, however,

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** Chief, Cardiac Catheterization Laboratory, Mount Sinai Hospital of Greater Miami, Miami Beach, Florida.*

definite, but mild left ventricular and left atrial enlargement are apparent.

Cardiovascular Hemodynamics

In most instances, intracardiac pressures and the cardiac index are normal. Rarely, mild elevation of left ventricular end-diastolic pressure and left atrial A wave is found.

Angiography

Cineangiography in the right or left anterior oblique projections demonstrates the characteristic mitral valve deformity. During early systole, the leaflets of the mitral valve balloon or prolapse backward into the left atrium as contrast material passes from the left ventricle into the aorta. Then, only during the latter part of the systole, does the contrast material regurgitate from the left ventricle to the left atrium.

The degree of mitral regurgitation is usually only mild to moderate and the left heart chambers are normal in size. A few patients have been seen, however, with more severe "late" mitral regurgitation with definite left atrial and left ventricular enlargement.

Simultaneous electrocardiograms, external and internal phonocardiograms, and pressure tracings have been compared with the cineangiographic data. There has been a fair correlation between the beginning of the late systolic murmur and the first appearance of the contrast material in the left atrium. The systolic click coincided with the timing of the maximum prolapsing of the mitral valve leaflets into the left atrium.

Clinical Course

In those patients with a late systolic murmur, mild mitral regurgitation, normal electrocardiogram and normal chest X-ray, initial studies have shown a relatively uncomplicated clinical course.

Since this type of murmur is heard so frequently in any diagnostic cardiac clinic, we believe that the lesion is generally benign. It is certainly possible that some of these patients may progress to the development of a holosystolic murmur and acquire the hemodynamic, as well as clinical characteristics of the more common forms of mitral valve insufficiency. Some of the patients with holosystolic murmurs may have begun their clinical course in this way and were not followed-up closely because of the initially benign course, and hence, the transition may have been missed. Only by recognizing and following closely the patient with the late systolic murmur, will the ultimate prognosis be known.

It must be appreciated, however, that some of these patients may develop bacterial endocarditis

following dental procedures. Therefore, the usual precautions against bacterial endocarditis should be instituted whenever a patient with this type of murmur is seen. We have, in addition, seen two patients with late systolic murmurs who had 3+/4 mitral regurgitation cineangiographically and definite mild left ventricular and left atrial enlargement. If their clinical course follows that of other forms of mitral valve disease, surgery may be necessary at some future time.

A group of patients has been described with late systolic murmurs and mid systolic clicks, abnormal T waves, prolonged Q-T intervals, prominent U waves and a high incidence of extrasystoles and paroxysmal tachycardia. A familial incidence was noted and also the occurrence of psychiatric disorders. One patient had seizures related to atrial flutter with 1:1 conduction and sudden death occurred in one patient.

Therefore, although the course in these patients is usually benign, the physician must guard against the development of bacterial endocarditis and be prepared to control the arrhythmia that may appear in those with abnormal resting electrocardiograms.

Miami Beach, Florida

REVISED VERSION OF CLINICIANS' HANDBOOK READY

The second edition of the *CRC Handbook of Clinical Laboratory Data* has been completely revised and expanded to 750 pages, including up-to-the-minute information on atomic absorption spectroscopy, electrophoretic fractionation of serum proteins, and ultraviolet visible absorption spectrophotometry. Edited by Drs. Willard R. Faulkner, John W. King and Henry C. Damm, the volume contains sections on clinical chemistry, blood banking, hematology, microbiology, and pathology.

The handbook sells for \$17 and may be ordered from bookstores or from the Chemical Rubber Co., 18901 Cranwood Pkwy., Cleveland, Ohio 44128.

GEORGIA RHEUMATISM SOCIETY

Spring Meeting

March 29

1:30-5:00 p.m.

Sheraton Biltmore Hotel, Atlanta

President: Colon H. Wilson, Jr., M.D.

Grady Hospital • 69 Butler St. S.E., Atlanta



GOVERNMENT HEALTH CARE PROGRAMS

AS NEAR AS I CAN ASCERTAIN, nobody knows all the workings of our Medicare programs. Most doctors are about as confused as other people concerning the programs and that does not exclude me. It is felt that a few simple fundamentals of these programs might be helpful.

Medicare and Medicaid

Public Law 89-97, the Social Security Amendments of 1965, established a health insurance program for the aged, consisting of a hospital insurance plan and a voluntary medical insurance plan.

Title 18

The hospital insurance plan affords basic protection to persons age 65 and over against the costs of in-patient hospital services, post-hospital home health services, and post-hospital extended care services.

Almost all persons 65 and over are eligible to enroll in the supplementary medical insurance plans. The plan covers 80 per cent of the cost of physician's services and other medical services after the beneficiary meets an annual \$50 deductible. Bills for services under the medical insurance plan are submitted by either the provider of service or the beneficiary to the carrier designated to act as intermediary for the Social Security Administration.

The intermediary for the State of Georgia is the John Hancock Insurance Company, Medicare Department.

Title 19

Public Law 89-97 also included provision for the payment by ratio of State and Federal funds for medical services for those who are unable to obtain these through their own financial resources. Persons who are eligible for benefits under this program include all categorical public assistance money payment recipients, residents eligible except for legal residence requirements, and individuals under the

age of 21 who are dependent children except for age or school attendance requirements.

Medicaid benefits include physician services, in-patient hospital services, exclusive of TB and mental disease out-patient hospital services, X-ray and laboratory services, skilled nursing home services, excluding TB and mental disease, and prescription drugs and supplies.

Carrier for the Medicaid Program is the Branch of Medical Assistance, Georgia Department of Public Health.

CHAMPUS

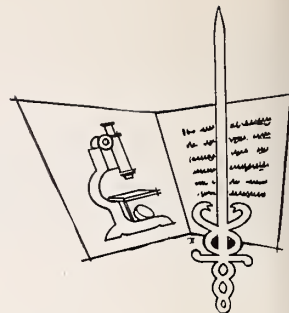
The Civilian Health and Medical Program of the Uniformed Services is administered by the Department of Defense and pays for hospital and medical services for spouses and children of active duty military personnel, retired personnel and their spouses and children, and spouses and children of deceased military personnel.

Benefits under this program include hospitalization, out-patient care, drugs, treatment of medical and surgical conditions, treatment of nervous, mental and chronic conditions, physical examinations, maternity and infant care, diagnostic tests and services, emergency dental care, ambulance service, and durable equipment.

Administrator of the CHAMPUS Program in Georgia is the Medical Association of Georgia.



*Charles R. Andrews, Jr.
President, Medical Association of Georgia*



MODERN TREATMENT OF CANCER

J. BENHAM STEWART, M.D., *Macon*

TOO OFTEN TODAY, when we think of the treatment of cancer, we think in terms of a big operating room with some complicated operative procedure being done, or of a super-voltage X-ray machine, or even of a highly technical perfusion apparatus. Strangely enough, however, the great advance in cancer that has been made in the past few years has not been in the extension of an over radical operation, but in the early detection of cancer when it is in an easily curable condition. In spite of our sophisticated methods for detection, women still find more of the cancers in their breasts than do physicians.

Importance of Family Physician

Our great medical centers are overflowing with well-trained surgeons, radiologists and chemotherapeutic experts, so the treatment of cancer can be relatively easily arranged. The family physician will have to be the backbone of the treatment in cancer, because it is he who sees the patient for routine matters and for small complaints which may be the first sign that he or she is developing a cancer. The early detection of cancer may take no more than simply thinking about it.

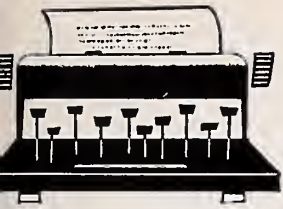
Every patient should have a physical examination at least once a year. This can be an office procedure unless some disease is found which would necessitate hospitalization. A Pap smear, as part of this physical, offers no real problem in the office. The only difficult part would be a sigmoidoscopic examination, and this can be included with very little additional effort.

Extended Follow-up

After the early detection, and treatment wherever the patient wishes to receive it, the family physician again looms large in the treatment of cancer, because patients must be followed, not only until they are over the immediate effects of treatment, but for the remainder of their lives, with routine examination and observation to rule out recurrences as well as new primary lesions.

It is going to take the entire team working together at top efficiency to do the job which remains to be done. In 1937 we were curing only one patient out of each five who presented themselves with cancer. Today we know we can cure one in two if we can only get them early enough. This should certainly be enough incentive to make everyone join the effort in earnest.

Dr. Stewart is Chairman of the Volunteer Patient Service Committee, American Cancer Society, Georgia Division, Inc.



Welcome to Savannah for Annual Session

THE GEORGIA MEDICAL SOCIETY welcomes you to historic Savannah. Recent renovations in the downtown area will be fascinating to those of you interested in the early life of the State of Georgia. To those of you staying in the downtown hotels and motels, I recommend the walking tours in the early morning hours. These tours are outlined in Chamber of Commerce brochures. The Harbor View Room of the DeSoto Hilton Hotel presents a beautiful panorama of the city—north to South Carolina, south, east, and west.

The beautifully renovated Savannah Inn and Country Club faces the Wilmington River, and, from its dock, many marshes, islands and hammocks meet your view. Skidaway Island is visible across the river to your left. The Oceanographic Science Center of the Atlantic is being built on Skidaway Island. Roads and bridges are now under construction and will provide access to the island by 1970.

Visit our fair city and enjoy one of the most interesting programs ever to be presented by the Medical Association of Georgia.

*John G. Zirkle, M.D.
President, Georgia Medical Society*

Medical Education

WHEN ONE LEAVES THE HOUSE at 5:30 a.m. on a Saturday morning and returns about midnight Sunday, having been to Chicago in the meanwhile, it seems like more than just a week-end has passed! The Annual AMA Congress on Medical Education, held in February, was a worthwhile experience, however.

There were four groups meeting simultaneously. Heading the list was the AMA Council on Medical Education, and its fine program. The Association for Hospital Medical Education had an interesting workshop. The discussion on the FLEX examination highlighted the meetings of the Federation of State Medical Boards of the United States. A Conference on Medical Education by the Student American Medical Association produced much comment.

Variety of Programs

The Council on Medical Education had programs on The Negro in Medicine, Curricular Design, Osteopathy, and Education of the Health Team, the last of which I moderated the panel discussion. Each of these programs explored in depth some of the inherent problems, and suggested both immediate and long

range goals to be sought. Other programs included discussion of some new approaches to health manpower production, and comments on implementing the Coggeshall report, the Millis report, the report of the Ad Hoc Committee on Education for Family Practice, and the report of the National Advisory Commission on Health Manpower. All of the programs will be covered in future issues of the JAMA.

Family Practice Board

One milestone announcement occurring as a result of the Advisory Board for the Medical Specialties meeting was the announcement of an approved American Specialty Board of Family Practice.

An excellent analysis of the FLEX examination was made, and this information will be useful for those of us from Georgia as we make our plans to utilize this method of licensing physicians here.

The comments from the students present well may be one of the most important aspects of the meeting. Present day medical students, and other students as well, are dissatisfied with methods of education, selection of students, and the degree of decision-making concerning their futures which is intrusted to them. Most of these students are highly intelligent, vocal, humane, and honest. They *will* be heard. Best we listen to them.

*John Rhodes Haverty, M.D.
Secretary, MAG*

Carl G. Bailey Joins MAG Staff As Field Representative

CARL G. BAILEY, formerly District Scout Executive in the Atlanta Area Council, has joined the staff of the Medical Association of Georgia as of March 1, 1969, as Field Representative.

Mr. Bailey has served as Assistant District Scout Executive in the DeKalb District and as District Scout Executive in the West Georgia District. He has also worked in other areas including management in the finance and collection field.

A native of north Georgia, Mr. Bailey is a graduate of the University of Georgia with a Bachelor of Business Administration degree. He is an active member of the United Methodist Church and has served in many capacities of leadership within his church.

Mr. Bailey now resides in Carrollton with his wife and their two children.

In his new position, Mr. Bailey will work closely in a liaison capacity between the Medical Association of Georgia headquarters office and Georgia county medical societies.





MORE ON PROFESSIONAL ASSOCIATIONS

JOHN L. MOORE, JR., *Atlanta**

CONSIDERABLE ACTIVITY in the Federal courts in tax cases has led to an increasing interest among professional persons in the formation of professional associations. Six District Courts of the United States have considered the tax status of professional associations or professional corporations as they are called in some States. In all six cases, the courts have decided in favor of the taxpayers and against the position of the United States Internal Revenue Service.

On January 7, 1969, the United States Court of Appeals for the Tenth Circuit decided a case in favor of a Colorado professional company practicing law. This is the first Federal Appellate Court decision on the subject. For that reason, and because of the clarity of the decision, it is very important.

History

Most physicians will remember the long battle between professional people and the Internal Revenue Service. In the 1920's, the Revenue Service, through a series of cases, established a rather strong position that certain trusts and partnerships would be taxed as corporations to the tax disadvantage of those groups. Beginning in the 1930's, professional persons realized that the taxable status of a corporation could be of tax advantage to professional people rather than a disadvantage. This comes about principally because the profit sharing plan of a corporation has much greater latitude than that allowed to partnerships or self-employed persons. The Revenue Service then reversed its position and tried to establish that groups with certain characteristics were really partnerships and not more like corporations. The Revenue Service lost this matter in the Kintner Case in 1954.

In 1960, the Revenue Service promulgated new regulations which sought to make it impossible for a partnership to establish its taxable status as a corporation. Consequently, most of the States adopted new legislation allowing formation of "professional associations" or "professional corporations." Under these new State statutes, the 1960 regulations of the Internal Revenue Service could be met so that the professional organizations could have been taxed as corporations.

However, the Internal Revenue Service took another step and in 1965 promulgated new regulations designed on their face to make it impossible for professional associations organized under the new State statutes to comply with the regulations defining taxable status as a corporation.

The Tenth Circuit decision in *U.S. v. Empey* now clearly holds that the 1965

* Prepared at the request of The Medical Association of Georgia. Mr. Moore is a member of the firm of Alston, Miller & Gaines, General Counsel to The Medical Association of Georgia.

regulations of the Internal Revenue Service are invalid, unreasonable, and plainly inconsistent with the Revenue statute. The Court denominated the 1965 regulation as "an attempt to legislate."

Present Status

To date, professional people seem to have been conservative in Georgia about the formation of professional associations. While the additional tax advantages available through a corporate profit sharing or pension plan can be sizable, the continuing battle with the Internal Revenue Service has always been a discouraging factor. At this particular point, the Revenue Service apparently will not concede the issue and will continue to contest it, at least in the circuits where there has been no appellate court decision. However, one seldom sees a line of cases so favoring the taxpayer without any decision in favor of the Revenue Service's position. If the Fifth Circuit Court of Appeals (the Circuit covering Georgia, Florida, Alabama, Mississippi, Louisiana, and Texas) should arrive at a decision following the Empey Case, it is clear that every group of physicians in the State should give consideration to the formation of a professional association.

Anticipate a Favorable Decision

It may be wise to give some consideration now to the formation of a professional association. It is possible that one can anticipate a favorable decision before the issues would become critical to the Georgia professional association. However, those who prefer to pay a few more dollars of taxes each year to the headaches and time consumed in worrying about opposing the Internal Revenue Service might well decide to wait until the issue is finally settled in the Fifth Circuit or possibly even by the Supreme Court of the United States.

*Suite 1220
C & S Bank Building*

"GEORGIA'S SILENT EPIDEMIC"

**Channel 11
WQXI-TV**

**March 25
9:30 p.m.**

This half-hour documentary on venereal disease was filmed in the metropolitan Atlanta area, and will cover all aspects of venereal disease, its control and symptomatology.

FUNDS ARE AWARDED FOR NURSES' TRAINING

Reducing dropouts from nursing schools, keeping teachers of nursing abreast of the most recent scientific advances in patient care, and increasing the quality of health services for disabled patients represent some of the aims of 21 new Projects for Improvement in Nurse Training which schools of nursing are undertaking with support from the Division of Nursing under the authority of the Nurse Training Act.

DeKalb College in Clarkston, has received a grant for a project which will focus on integrating mental

health concepts into an associated degree nursing education. The project will last for one year.

According to the Division of Nursing, 16 nursing education programs in hospitals and community colleges are participating in nine of the new Projects for Improvement in Nurse Training. Projects are also underway in 12 graduate and undergraduate nursing programs in colleges and universities. Funds now awarded to launch and carry the 21 new projects through their first year of operation total \$1,078,902.



EPIDEMIOLOGY OF CARDIOVASCULAR DISEASES

GLEN E. GARRISON, M.D., *Augusta*

EPIDEMIOLOGY IS THE STUDY of the distribution of various diseases or findings in specific populations. The correlation of the presence or subsequent development of diseases with various environmental and hereditary factors frequently reveals associations between diseases and other factors.

General Principles

Associations are at times based on a factor that is a cause of the disease, and in other instances the factor having a positive correlation with a disease is not a causative factor but an incidental one produced by the underlying cause of the disease. Even though the association between a factor and a disease is unquestionable statistically, modification or removal of the factor will not influence the disease or the likelihood of developing the disease unless the factor has a causative relationship to the disease. Once associations have been identified, additional research projects must be developed with appropriate control groups to see if modification of the factor associated with the disease will improve the disease or make its initial development less likely. The comments in this paragraph are general principles and are applicable to all diseases. These principles are simple and easy to comprehend but unfortunately get blurred at times and sometimes are virtually unidentifiable when specific diseases are discussed in an environment of emotional commitment. The point most often overlooked is that associations are not necessarily based on a direct causative relationship.

Epidemiological research has provided a tremendous amount of information about cardiovascular diseases. A large portion of the current information is documented highly significant associations. Some of these associations have been demonstrated to have a cause and effect relationship, often leading to the development of successful programs of prevention and control of specific cardiovascular diseases. On the other hand, some associations have been shown to be incidental, and still others cannot be clearly classified into either group with currently available information.

Primary Sources of Data

Successful cardiovascular epidemiology has primarily utilized the following sources of data:

- (1) Vital statistics (especially mortality data from death certificates)
- (2) Prevalence or cross-sectional surveys (the study of disease in a population at a particular time)
- (3) Incidence or prospective surveys (the study of the development of new cases of disease in a population during an interval of time)

HEART PAGE / Continued

- (4) Field or clinical trial (division of a population by a random method into two groups with one group receiving a possibly beneficial therapeutic agent or procedure and the other group serving as a control).

The other epidemiological method that has been commonly used is the *retrospective study* in which people with a disease and those without the disease are identified, and attempts are made to compare their previous medical history in search of significant differences. This method is usually faster and less expensive than the others, but it has so many inherent dangers for the introduction of errors that information developed by it should usually not be considered definitive.

During the next several months the Heart Page will contain brief summaries of the current status of prevention and/or control of various major cardiovascular diseases. These control measures have been developed to a large degree by the previously outlined epidemiological methods. Consequently, clinical physicians should keep the principles of these methods in mind when formulating their opinion of proposed or controversial preventive and therapeutic measures.

Medical College of Georgia

HEART ASSOCIATION EXPANDS CPR PROGRAM

The kickoff of the Georgia Heart Association's newly expanded statewide Cardiopulmonary Resuscitation program was held recently, with physicians from 37 hospitals and 22 key State cities in attendance.

The Faculty Training Workshop, conducted by GHA with the support of the Georgia Regional Medical Program, was held on November 1-2, at the National Communicable Disease Center and the Woodruff Memorial Research Center at Emory University. Course Director was Archer S. Gordon, M.D., Chairman of American Heart Association's Committee on Cardiopulmonary Resuscitation.

Instructors Recruited

Creation of the core faculty is the first step in GHA's plan to train instructors throughout the State. When those instructors become available, the CPR technique will be offered to selected groups in each

community, including dentists, nurses, firemen, law enforcement officers, life guards and others in hazardous occupations.

Virtually all hospitals represented at the Workshop have begun in-service training programs for all personnel in their respective hospitals.

Faculty instructors will, in turn, conduct instructor training sessions for physicians and nurses in all hospitals within a fifty-mile radius of their respective cities.

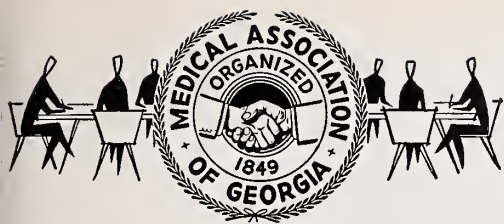
The Medical Association of Georgia is pleased to have a part in this effort through the Georgia Regional Medical Program. The response elicited by this project to date is most gratifying. We commend this effort to physicians and to hospitals throughout Georgia and urge that each hospital see that its in-service training program in cardiopulmonary resuscitation meets the standards of the American Heart Association.

BREAST CANCER IS CONFERENCE TOPIC

The National Conference on Breast Cancer will be held at the Shoreham Hotel in Washington, D.C. on Thursday, Friday and Saturday, May 8-10, 1969. A multidisciplinary review of the breast cancer problem in the United States will be presented, including epidemiology, etiology, detection, diagnosis, management and control measures. Disappointing as well as successful approaches in combatting the disease will be discussed in an effort to identify possible directions for future progress.

The conference is sponsored by the American Cancer Society and the Cancer Control Program of the United States Public Health Service. All members of the medical and related professions, and research investigators are invited to attend this conference. There is no registration fee. Preregistration is requested.

For further information, write Roald N. Grant, M.D., National Conference on Breast Cancer, American Cancer Society, 219 East 42nd Street, New York, N.Y. 10017.



THE ASSOCIATION

NEW MEMBERS

Christensen, Eunice H., M.D. Active—Thomas-Brooks—Anes.	John D. Archbold Memorial Hospital Thomasville, Georgia 31792
Christensen, Everett D., M.D. Active—Thomas-Brooks—GP	John D. Archbold Memorial Hospital Thomasville, Georgia 31792
Curtis, John R., M.D. Active—Crawford W. Long—P	University Health Service Athens, Georgia 30601
Eyres, Thomas E., M.D. Active—Crawford W. Long—GP	University Health Service Athens, Georgia 30601
Franco, Ned M., M.D. DE-2—Fulton—U	69 Butler Street, S.E. Atlanta, Georgia 30303
Gonzalez, Victor R., M.D. Active—Fulton—P	3390 Peachtree Road, N.E. Atlanta, Georgia 30326
Kahn, Eric M., M.D. Active—Fulton—SU	340 Boulevard, N.E. Atlanta, Georgia 30312
King, Stephen H., M.D. Active—Crawford W. Long—I	University Health Service Athens, Georgia 30601
Leader, Edward, M.D. Active—Fulton—P	1999 Cliff Valley Way, N.E. Atlanta, Georgia 30329
Levine, Stanley H., M.D. Active—Fulton—OBG	3312 Piedmont Road, N.E. Atlanta, Georgia 30305
Lipscomb, George E., M.D. Active—Muscogee—R	Medical Center Columbus, Georgia 31902
Neufeld, Jocelyn R., M.D. Active—Crawford W. Long—Anes.	135 Gatewood Place Athens, Georgia 30601
Quinn, Francis B., Jr., M.D. Active—Fulton—OALR	144 Ponce de Leon Avenue, N.E. Atlanta, Georgia 30308
Rawlings, Joe D., M.D. Active—Thomas-Brooks—GP	Medical Building Thomasville, Georgia 31792
Steinhauer, James J., M.D. Active—Muscogee—Anes.	406 Doctors Building Columbus, Georgia 31901
Theus, Thomas L., M.D. Active—Muscogee—I	2039 Warm Springs Road Columbus, Georgia 31904
Tumlin, William D., M.D. Active—Crawford W. Long—GP	Lexington, Georgia 30648
Weaver, Richard J., M.D. Active—Crawford W. Long—Path.	St. Mary's Hospital Athens, Georgia 30601

SOCIETIES

Catherine E. Foster has been installed as president of the **DeKalb County Medical Society**. New officers elected for 1969 are Timothy Hardin, president-elect; Frank E. Morgan, Jr., vice-president; Angier Wills,

secretary-treasurer, and L. L. Freeman, corresponding secretary.

PERSONALS

Second District

Albany internist **Charles D. Hollis, Jr.**, was a delegate from the Georgia Society of Internal Medicine to a regional meeting of the American Society of Internal Medicine. The meeting took place in Tampa on January 24-26.

Fifth District

Dr. and Mrs. **Ralph Deas** have returned from attending the Fourth Biennial Ophthalmological Contact Lens Congress held at the Fontainebleau Hotel in Miami Beach. Dr. Deas was a guest speaker at the meeting and presented a paper on "The Successful Bifocal Contact Lens."

Ilhan M. Ermutlu, director of the Community Services Branch, Division of Mental Health of the Georgia Department of Public Health, has been elected a fellow of the American Public Health Association.

Several Atlanta physicians have been elected to posts in the Southern Medical Association for 1969. They include **Henry M. Finch**, vice-chairman of the Section on Proctology; **Joseph Yampolsky**, vice-chairman of the Section on Pediatrics; **F. Phinizy Calhoun, Jr.**, chairman of the Section on Ophthalmology; **John S. Turner, Jr.**, chairman-elect of the Section on Otolaryngology; and **James V. Rogers, Jr.**, chairman-elect of the Section on Radiology. They will be responsible for arranging the programs for their various sections at the annual meeting of the Association which will be held in Atlanta November 10-13.

Bernard C. Holland has been named to the National Advisory Mental Health Council. The NAMHC is an advisory board to the Administrator of the Health Services and Mental Health Administration on matters of research, training, and community mental health programs supported by the National Institute of Mental Health.

The Year Book Medical Publishers of Chicago have recently notified **Bernard Lipman** that the fifth edition of his book, "Clinical Scalar Electrocardiography," has been translated and published in the Italian language. It has been previously translated and published in Japanese, Spanish (Argentine version), French and Spanish (Mexican version).

Bruce Logue of Atlanta was a recent guest lecturer at Frontiers of Medicine 1969, sponsored by the Lakeland Graduate Medical Assembly at Cypress Gardens, Florida.

Seventh District

New officers of the John L. Hutcheson Memorial Tri-County Hospital in Dade County are **John C. Ellis**, chief-of-staff; **W. D. Crawley**, vice chief-of-staff; and **Murphy K. Cureton**, secretary. Other members of the

THE ASSOCIATION / Continued

executive committee of the medical staff include **Charles R. Swift**, chief of medical services, and **Warren Terrell**, past chief-of-staff.

Gwynne H. Little of Trion has announced his resignation from the staff of Trion Community Hospital and his retirement from the practice of medicine as of January 1.

The new chief of the Gordon County medical staff is **Bill Purcell** of Calhoun. Also elected to serve with Dr. Purcell were **Lewis R. Lang**, assistant chief and **Joseph A. Bishop**, secretary.

Tenth District

Louis G. Cacchioli of Hartwell has been named chief-of-staff of the Hart County Hospital. He succeeds **Terrell B. Tanner**. Also named was **Randall E. Couch** of Lavonia, secretary.

Augusta internist **Alex Murphy** attended the regional meeting of the American Society of Internal Medicine as a delegate from the Georgia Society of Internal Medicine. The meeting was held in January.

The Section on Anesthesiology of the Southern Medical Association has elected **Z. W. Gramling** of Augusta as secretary for 1969.

DEATHS

Rudolph A. Bartholomew

Atlanta obstetrician and author Rudolph A. Bartholomew died January 5 at the age of 82.

A native of Des Moines, Iowa, he received his M.D. from the University of Michigan, and in 1918 he became superintendent of Grady Hospital. He engaged in a great deal of research in obstetrics, especially on toxemia and hemorrhage, and his book "What to Do in Emergency Child Birth in Times of Disaster," is highly regarded in civil defense planning and has been reprinted for several State civil defense groups. Dr. Bartholomew also invented an obstetric labor bed used in many hospitals today.

Practicing in Atlanta since 1917 when he became associated with the Emory University School of Medicine, Dr. Bartholomew retired from Emory in 1955 as a clinical professor of obstetrics. He was made a Clinical Doctor Emeritus of the Emory University School of Medicine, and in 1966, the operating room at Grady Hospital was named for him. He received the Aven Cup in 1956 from the Fulton County Medical Society for outstanding leadership in his community and in medicine, and the Hardman Award in 1963 from the Medical Association of Georgia.

Survivors include his wife, the former Rubye Deckle; two sons, Donald D. Bartholomew of Utica, Mich., and Dr. Philip R. Bartholomew of Atlanta; two daughters, Dr. Gale D. Hill of Raleigh, N.C., and Miss Lucille Bartholomew of Atlanta, and three sisters, Miss Marguerite Bartholomew and Mrs. Rebecca East, both of Atlanta, and Mrs. William G. King of Detroit.

Steven T. Brown

A former president of the American Medical Association, Steven T. Brown of Atlanta, died January 2 at Emory University Hospital.

In addition to his leadership of the AMA, Dr.

Brown was also a past president of the Fulton County Medical Society and past president of the Georgia Baptist Hospital staff. He was a charter member of the Urological Association, and a member of the Southern Urological Congress.

Survivors include his wife, the former Ethel Green; a daughter, Mrs. J. Frank Walker of Atlanta; a sister, Mrs. Tom Peeples of Smyrna, and two brothers, Fred Brown of Eton, and S. Ross Brown of Grandridge, Fla.

Edgar F. Fincher, Sr.

Atlanta neurologist and former Emory University professor of neurology, died January 12 in an Atlanta hospital at the age of 68.

A member of the staff of eight hospitals, Dr. Fincher received his B.S. degree from Emory University and his M.D. from Emory in 1925. He began his practice in brain surgery in 1930, having interned at Piedmont Hospital and done postgraduate work at Peter Bent Brigham Hospital in Boston. He was a Fellow in neurological surgery at Washington University in St. Louis and at the Mayo Foundation at the University of Minnesota.

Dr. Fincher was a founding member of the American Board of Neurological Surgery and the Southern Neurological Society, and was a former president of the Harvard Cushing Society. He also held memberships in the Southern Surgical Association, the American College of Surgeons, the American Medical Association, the Medical Association of Georgia and the Fulton County Medical Society.

Survivors include his wife, the former Helen Nichols; a son, Edgar F. Fincher, Jr., of Seattle, and a sister, Mrs. William Trimble of Atlanta.

Harry C. King

Harry C. King of Griffin, died December 31 after a short illness.

A native of Toccoa, Dr. King received his M.D. degree from Emory University, and began his practice in obstetrics and gynecology in Griffin in 1945. He was a Fellow of the American College of Obstetricians and Gynecologists, a member of the Spalding County Medical Society, the Medical Association of Georgia, and the American Medical Association.

Survivors include his wife, Mrs. Lois Campbell King; two daughters, Mrs. Robert Phillips of Atlanta and Miss Linda King of Griffin; a son, Lt. Harry C. King, Jr., Fort Bliss, El Paso, Texas; his mother, Mrs. W. R. King, Sr.; two brothers, Dr. W. R. King, Jr., and Dr. J. Lamar King, all of Griffin.

Paul T. Russell

Albany physician Paul T. Russell, 52, died unexpectedly December 26, 1968.

Born in Sylvester, Dr. Russell attended the University of Alabama and received his M.D. degree from the University of Louisville, before starting his general practice in Albany.

Survivors include his wife, the former Lucille Skelton; a daughter, Miss Janet Russell; three sons, 1st Lt. Paul T. Russell, Jr., U.S. Army, TuNghi, South Vietnam; Robert W. Russell, U.S. Navy; and William P. Russell; his mother, Mrs. Thomas P. Russell of St. Simons Island, and a sister, Mrs. Wade H. Hester, Jr., of Albany.

HIGHLIGHTS OF EXECUTIVE COMMITTEE OF COUNCIL MEETING, JANUARY 12, 1969—ATLANTA

This summary is being published so that members may be advised of the actions of the Executive Committee between meetings of Council. It covers only major actions and is not intended as a detailed report in lieu of meeting minutes.

Georgia State Nurses Association Activities—Recent events surrounding DeKalb General Hospital nurses, and efforts to gain recognition, were discussed with representatives of the Hospital and the Georgia State Nurses Association. President appointed a Special Committee of Charles Eberhart, M.D., Chairman; John T. Godwin, M.D.; and John T. Mauldin, M.D., to formulate a position statement by January 21, 1969.

Legislation for a Joint Examining Board to License M.D.'s and D.O.'s—A report of the vote of the Fulton County Medical Society Board opposing the legislation to create a joint Examining Board was received for information, and action to proceed with the drafting of the bill as directed by Council was approved.

Mental Patients' Bill of Rights—On recommendation of the Committee on Legislation, voted approval of the Medical and Psychiatric Principles of the Mental Pa-

tients' Bill of Rights, but declined to endorse the economic and legal principles involved.

Psychology Association Legislation—On hearing recommendations from the Committee on Insurance and Economics, and others, active opposition to the proposed bill was voted.

Psychiatric Hospital Legislation—Received for information a report from Z. Sweeny Sikes, M.D., Macon, that he will introduce a bill on health insurance which would have all carriers include in their contracts coverage for care rendered in psychiatric hospitals licensed by the Georgia Department of Public Health.

Life of Georgia Group Policy Ownership—On recommendation of the Committee on Insurance and Economics approval of a member's request was voted granting him the privilege of transferring all rights in his MAG group life policy to his wife.

Marion County Memorial Hospital Dispute—The Executive Secretary was directed to contact the Medical Staff to impress upon them the importance of requesting MAG mediation of their dispute with the Hospital Governing Board. In the absence of this request, the County Commission and the Governing Board will then be written explaining MAG's inability to mediate unless all parties agreed to request it.

*"Either we shall master the ways
of Political Action, or we shall be
mastered by those who do."*

JOIN
GAMPAC



George A. Holloway, M.D. of Atlanta shares a light moment with the Speaker of the House, George L. Smith, III, on the rostrum in the House Chamber while serving as Doctor of the Day.

BOSTON WILL HOST AAP SPRING SESSION

Youth in revolt, critical congenital heart disease in newborn infants, the short child, changing patterns of pediatric care, and pediatric emergencies will be among the many subjects to be discussed during the American Academy of Pediatrics' annual spring session April 21-23 in Boston, Mass.

The meeting will feature closed-circuit color television clinical presentations, a diversified scientific program, and more than 90 scientific and technical exhibits. One panel discussion, entitled "Pediatric Pot Pourri" will include presentations on tetanus immuni-

zation, mumps immunization, and comparison of immunity status of children in the inner city and in the suburbs.

Other special activities will include a panel discussion sponsored by the Academy Head Start Medical Consultation Service entitled "Problems of a Head Start Consultant," a special luncheon meeting of the Academy's Council on Pediatric Practice on Monday, April 21, and the centennial celebration of the Children's Hospital Medical Center in Boston.

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Grady Memorial Hospital Auditorium

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CALENDAR OF MEETINGS

In Georgia

- March 14-15—American Burn Association, Regency-Hyatt House, Atlanta.
 March 15—AMA Regional Workshop for State Chairmen of Committees on Medicine and Religion, Air Host Inn, Atlanta.
 March 27-29—Southern Society of Anesthesiologists, Marriott Motor Hotel, Atlanta.
 April 7-9—Postgraduate course on "Pharmacology for the Anesthesiologist," Emory University, Atlanta.
May 4-7—115th MAG Annual Session, Savannah Inn and Country Club, Savannah.

National

- March 15-19—American Academy of Allergy, Americana Hotel, Bal Harbour, Fla.
 March 19—Council on Rural Health, Sponsored by AMA Department of Health Education, Marriott Motor Hotel, Philadelphia, Pa.
 March 19-23—Sixth Annual Institute on Diabetes, Sponsored by Colorado Diabetes Association, Aspen Institute, Aspen, Col.
 March 20—Meeting for State Medical Association Rural Health Committee Chairmen, Marriott Motor Hotel, Philadelphia, Pa.
 March 20-22—American Academy of Facial Plastic and Reconstructive Surgery, The Royal Orleans, New Orleans, La.
 March 21-22—National Conference on Rural Health, Sponsored by AMA Council on Rural Health, Marriott Motor Hotel, Philadelphia, Pa.
 March 23-24—American Laryngological Association, Roosevelt Hotel, New Orleans, La.
 March 23-24—American Society for Head and Neck Surgery, Roosevelt Hotel, New Orleans, La.
 March 25-26—American Broncho-Esophagological Association, Roosevelt Hotel, New Orleans, La.
 March 25-27—American Laryngological, Rhinological and Otological Society, Roosevelt Hotel, New Orleans, La.
 March 27-29—AMA Board of Trustees, AMA Headquarters, Chicago, Ill.
 March 28-29—American Otological Society, Roosevelt Hotel, New Orleans, La.
 March 28-29—AMA National Congress on the Socio-Economics of Health Care, Palmer House, Chicago, Ill.
 March 29-30—American Association of Suicidology, Americana Hotel, New York, N.Y.
 March 30-April 2—American Orthopsychiatric Association, Americana Hotel and New York Hilton Hotel, New York, N.Y.
 April 1-4—American Association of Anatomists, Sheraton-Boston Hotel, Boston, Mass.
 April 5-6—Southeastern Dermatological Society, Lloyd Noland Hospital, Birmingham, Ala.
 April 9-10—American Association of Planned Parenthood Physicians, St. Francis Hotel, San Francisco, Calif.
 April 12-13—National Guild of Catholic Psychiatrists, Washington, D.C.

- April 13-17—American Association of Neurological Surgeons, Sheraton Cleveland Hotel, Cleveland, Ohio
 April 17-19—Orthopaedic Symposium, "Problems of the Knee—Traumatic and Reconstructive," Warwick Hotel, Houston, Tex.
 April 17-22—American Dermatological Association, Marriott's Camelback Inn, Scottsdale, Ariz.
 April 18-19—Seminar on Arthritis and Collagen Diseases, Mayflower Hotel, Jacksonville, Fla.
 April 18-20—American Society of Internal Medicine, Palmer House, Chicago, Ill.
 April 20-25—American College of Physicians, Conrad Hilton, Chicago, Ill.
 April 21-23—American Academy of Pediatrics, Boston, Mass.
 April 21-24—Industrial Medical Association, Shamrock Hilton, Houston, Tex.
 April 21-26—American Academy of Neurology, Washington Hilton, Washington, D.C.
 April 27-May 1—Southeastern Surgical Congress, Roosevelt Hotel, New Orleans, La.
 April 28—National Cystic Fibrosis Research Foundation, Marlborough-Blenheim Hotel, Atlantic City, N.J.
 April 28-May 1—American College of Obstetricians and Gynecologists, The Americana, Bal Harbour, Fla.
 April 28-30—American Radium Society, Bellevue Stratford, Philadelphia, Pa.
 April 28-May 1—Southeastern Surgical Congress, Roosevelt Hotel, New Orleans, La.
 April 29—American Society of Therapeutic Radiologists, Bellevue Stratford, Philadelphia, Pa.
 April 29-May 3—Student American Medical Association, LaSalle Hotel, Chicago, Ill.
 April 30-May 1—American Pediatric Society, Traymore Hotel, Atlantic City, N.J.
 April 30-May 2—American Surgical Association, Netherland-Hilton, Cincinnati, Ohio
 April 30-May 3—Neurosurgical Society of America, Key Biscayne Hotel, Key Biscayne, Fla.
 April 30-May 3—American Association of Plastic Surgeons, Fairmount Hotel, San Francisco, Calif.

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PEDIATRICIAN—Coordinator, Child and Social Health Services with the Fulton County Department of Public Health. Salary Range: Monthly: \$1,270-\$1,613; Yearly: \$15,240-\$19,356. Qualifications: Licensed to practice medicine in Georgia. Experience in pediatrics and graduate degree in public health desirable. May consider a well-qualified person on a part-time basis. For more details and to apply, contact: Fulton County Civil Service Board, Room 310, County Administration Building, 165 Central Ave., S.W., Atlanta, Ga. 30303. Phone 572-2383.

TO SUBLEASE: Doctor's suite in medical building, two blocks from Dekalb General Hospital, Decatur, Georgia. Contact James E. Anthony, Jr., M.D., Suite 717, 755 Columbia Drive, Decatur, Georgia.

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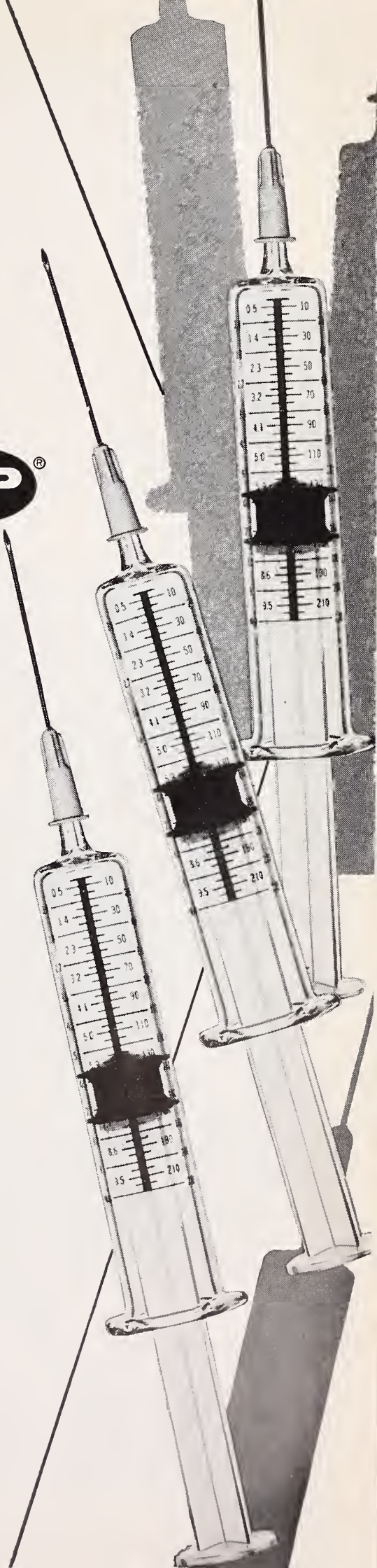
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Design by Ike Hussey, Higgins, McArthur, Longino & Porter, Atlanta.

*A report of two cases and review of
previously reported cases.*

Bilateral Brenner Tumors of the Ovary

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THE BRENNER TUMOR is an uncommon neoplasm of the ovary. Since Fritz Brenner¹ described the first three cases in 1907, the number of reported cases has reached 500.³ Peck and Leary¹³ estimate that this tumor occurs in only two per cent of all solid ovarian neoplasms. Bilateral Brenner tumors are more infrequent, being present in approximately six per cent of the reported cases. However, this figure is probably high since not all of the unilateral types are reported.

Histologically, these solid encapsulated tumors are composed of multiple epithelial cell nests surrounded by a dense fibromatous matrix. Occasionally this growth has been associated with other ovarian neoplasms; e.g., pseudomucinous cystadenocarcinoma,⁴ and benign and malignant teratoma.⁵ Other associated pathology includes endometrial carcinoma, which was found in 23 per cent of the cases in one series.⁶

Generally Benign Tumors

It is generally accepted that Brenner tumors are benign, although malignancies have been reported. Idelson¹² reviewed the literature and found a total of 25 cases, to which he added one case of his own. Further spread was found primarily to be by local extension. Once diagnosed, the malignancy proved fatal within six months in a majority of cases.

The histogenesis of this tumor is still unsettled. Brenner originally described this neoplasm as an "oophoroma folliculari" because of its similarity to theca cell tumor. Numerous origins have been suggested: the epithelial surface of the ovary,⁷ the granulosa cell,⁸ the ovarian stroma and the rete ovarii,⁷ the teratoma,⁹ the Wolffian duct,¹⁰ and the Walthard rest.^{2, 5}

It is of interest to note that the first 17 cases reported in the literature were bilateral. Since then, the total number of bilateral cases has risen to 35.^{3, 5, 8, 11, 13-28} Of these 35 reports, there are only 23 in which some form of case history was presented. It is the purpose of this paper to analyze these 23 cases together with two cases of our own.

Materials and Methods

In the period from 1954 to 1967, 19 cases of Brenner tumors were seen on the Gynecology service at Grady Memorial Hospital, Atlanta, Georgia. Of these cases, two were found to have bilaterally occurring tumors.

Review of the literature revealed 23 cases with some form of case history (Table 1). These reports, plus the two cases presented here, were examined in regard to the following: age, parity, menopausal status, chief complaint, uterine pathology, ovarian tumor size, and associated ovarian pathology. If the menopausal status was not stated, those patients less than 40 years of age were presumed as premenopausal and those greater than 60 years of age as postmenopausal.

Report of Cases

Case 1: W.H., 59 years old, G₄P₂A₂, was admitted on 4/19/65 after three months of postmen-

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opausal bleeding. She had experienced a spontaneous menopause ten years previously. Her menstrual history included episodes of menorrhagia and dysmenorrhea.

Physical examination was essentially unremarkable; pelvic exam revealed a small, mobile uterus, clean cervix and no adnexal masses.

Four days after admission an examination under anesthesia and a diagnostic dilation and curettage were performed. At this time a right adnexal mass was palpated. The mass was firm, mobile and measured approximately 3 x 5 cm. Pathological diagnosis of the endometrial curettings was polypoid cystic hyperplasia.

Enlarged Ovary

One week after admission an exploratory laparotomy revealed an enlarged, firm right ovary which on frozen section was reported as a probable Brenner tumor. The left ovary was not mentioned in the operative record. A total abdominal hysterectomy and bilateral salpingo-oophorectomy were then performed without complication. The post-operative course was unremarkable and the patient was discharged seven days after surgery.

Macroscopic findings: The uterus measured 7.5 x 4.8 x 3.2 cm. At the anterior uterine wall near the right cornu was a polypoid structure measuring 2.5 x 1.2 x 0.8 cm. Both fallopian tubes were unremarkable. The right ovary was replaced by a firm, well encapsulated mass measuring 3.8 cm. in greatest diameter. The cut surface of this mass revealed inter-lacing whorls of grayish-white tissue. The left ovary measured 2.5 x 1.8 x 1.6 cm.

Microscopic findings: The endometrium showed cystic change but no evidence of marked hyperplasia was present. There were several microscopic endometrial polyps which appeared benign.

The right ovary contained many round, oval and compactly filled nests of epithelioid cells surrounded by a dense irregular fibrous pattern (Figure 1). The cells within the epithelial nest contained granular cytoplasm which occasionally was vacuolated. The left ovary slightly differed from the right in that most of the epithelial cell nests were smaller and less numerous per low power field. In addition, the epithelial cell cytoplasm was more eosinophilic and rarely contained vacuoles. Both Brenner tumors appeared benign.

Second Case

Case 2: W.M., 62 years old, G₃P₀A₃, was admitted on 5/31/67 after a two-year history of in-

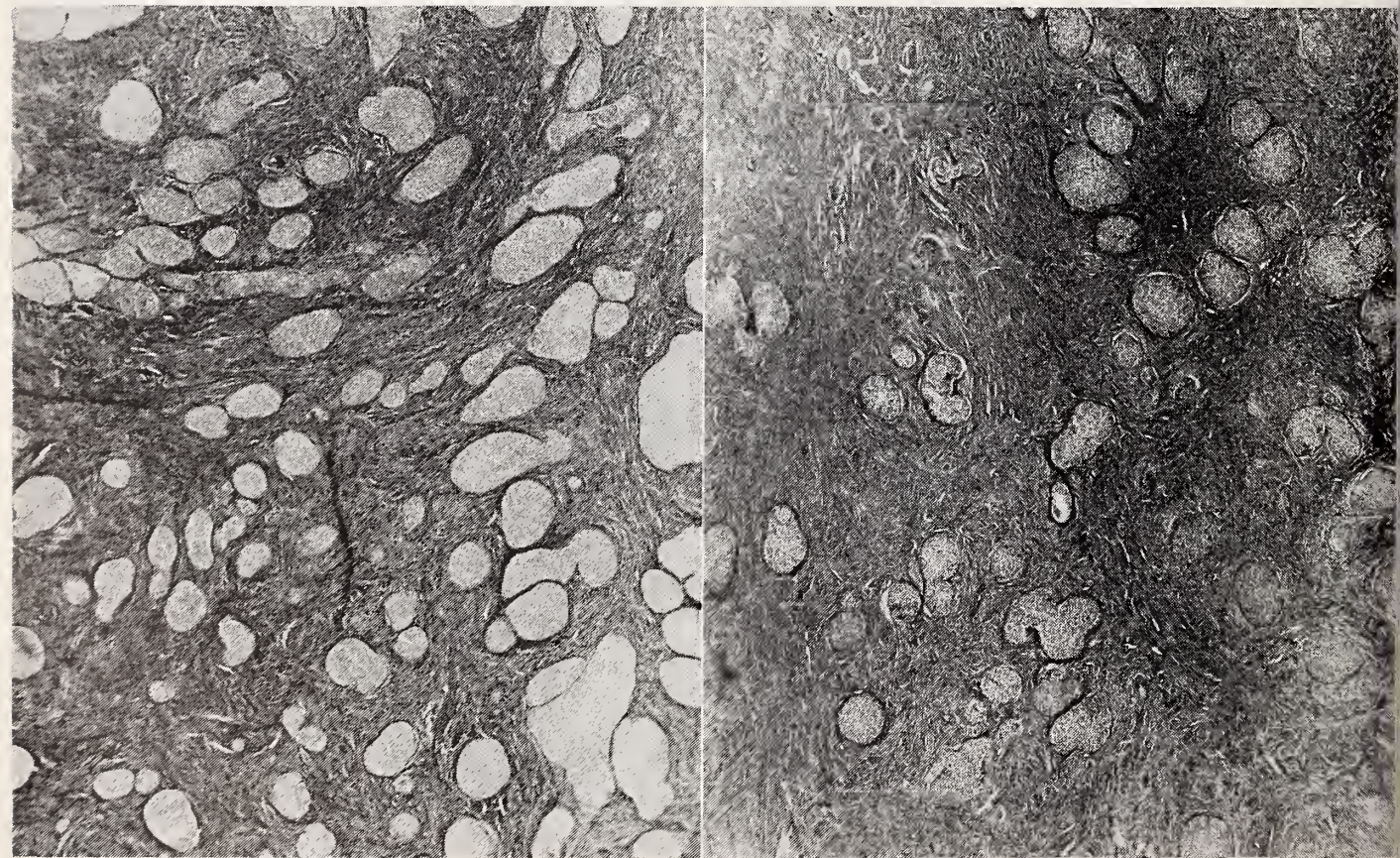


FIGURE 1

Brenner tumors from patient W.H. Note increased size and number of epithelial cell nests in right ovary (a) as compared to left ovary (b) (x100, H&E).

TABLE 1
PREVIOUSLY REPORTED CASES OF BILATERAL BRENNER TUMORS WITH CASE HISTORIES

Case No.	Author, Date	Age (yrs.)	Parity	Post-menopausal	Chief Complaint	Uterine Pathology	Ovarian Tumor Size (cm)
1	Johnson and Dockerty, 1940	47	G ₅ P ₃ A ₂	N.S.	Pelvic heaviness	Multiple leiomyomata	L—6 × 6 R—6 × 5 × 4
2	Fox, 1942	42	G ₂ P ₂ A ₀	No	Menometrorrhagia	Multiple leiomyomata	*3.5 × 2.5 × 1.2 3.8 × 2 × 1.8
3		39	G ₃ P ₀ A ₃	N.S.	RLQ pain with backache	TAH 2 yrs. previous for leiomyomata	*4 × 1.5 × 0.5 4 × 2 × 1.2
4		45	G ₁ P ₀ A ₁	N.S.	Abdominal mass	N.S.	L—4 × 3.5 × 2.5 R—13 × 10 × 7
5		34	G ₁ P ₁ A ₀	No	Severe dysmenorrhea	N.S.	L—3.5 × 2 × 1.2 R—4.5 × 4 × 3
6	Pearle, 1942	50	N.S.	N.S.	Abdominal swelling	N.S.	12 × 7 12 × 8 × 7
7	Peck and Leary, 1952	35	G ₂ P ₂ A ₀	N.S.	Back pain	N.S.	L—2 × 2 R—4 × 5
8	Teoh, 1953	67	N.S.	N.S.	Vaginal bleeding	Leiomyomata, endometrial hyperplasia	L—15 × 3 R—4 × 5
9		64	N.S.	N.S.	N.S.	N.S.	12 × 12 microscopic
10	Flanagan and Race, 1954	62	G ₁ P ₁ A ₀	8 yrs.	Nausea and vomiting	Leiomyomata	L—18 × 10 × 9 R—18 × 15 × 10
11	Rawson and Helman, 1955	70	N.S.	25 yrs.	LLQ pain	Invaded with malignant Brenner tumor	L—5 × 3.5 × 4 R—5 × 6 × 7
12	Postloff and Sotto, 1956	78	N.S.	N.S.	N.S. (post mortem specimen)	Not remarkable	L—5 × 5 × 3.2 R—pinpoint
13		56	N.S.	N.S.	N.S.	Not remarkable	L—1.5 × 1.5 R—10 × 8 × 5.5
14	Bungard and Hang, 1959	36	G ₃ P ₃ A ₀	N.S.	Breast tumor	N.S.	L—4 × 2 × 2 R—4 × 2 × 2
15	Farrar and Greene, 1960	48	G ₂ P ₀ A ₂	4 yrs.	RLQ pressure	Atrophic endometrium	L—2.7 diam. R—8.5 diam.
16		47	G ₃ P ₃ A ₀	No	Lower abdominal pain	Leiomyomata, adenomyosis	L—7.5 diam. R—1.5 diam.
17	Kendall and Bowers, 1960	34	G ₃ P ₂ A ₁	N.S.	Pelvic pressure	Endometrial polyp, endometrial hyperplasia	L—10 × 9 × 8 R—4 × 2 × 1
18	Kretchmer, Dietel and Goodale, 1962	49	G ₁ P ₁ O ₀	No	RLQ pain	Leiomyomata	L—2 × 1.5 × 0.5 R—0.5 × 0.5
19		65	G ₂ P ₂ A ₀	15 yrs.	No gynecologic complaint—incidental finding at surgery	N.S.	L—7.0 × 6.5 R—2.5 × 2
20	Christian and Janowski, 1963	44	G ₂ P ₂ A ₀	No	Menometrorrhagia	Leiomyomata	L—4.5 × 4 × 1.5 R—4.5 × 2 × 2
21	Badway, Jorgensen and Cromer, 1964	37	G ₀ P ₀ A ₀	No	Abdominal mass enlarging	Leiomyomata, proliferative endometrium	L—12 × 10 × 9 R—10 × 8 × 7
22	Varden, 1964	47	N.S.	No	Adnexal mass palpated	Secretory endometrium	5.5 diam. 3.5 diam.
23	Muscat, 1965	67	G ₀ P ₀ A ₀	23 yrs.	Vaginal bleeding	Leiomyomata, proliferative endometrium with atypia	L—4.5 × 3 × 3.8 R—2.8 × 1.8 × 1.8 (Walthard rest in one ovary)
24	(This study)	59	G ₁ P ₂ A ₂	10 yrs.	Post-menopausal bleeding	Endometrial polyps, inactive endometrium with cystic change	L—2.5 × 1.8 × 1.6 R—3.8 diam.
25		62	G ₃ P ₀ A ₃	5 yrs.	Post-menopausal bleeding	Leiomyomata, active endometrium	L—7 × 5 × 3 R—1.3 diam.

N.S.—Not stated.

* Side was not stated.

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termittent postmenopausal bleeding. She had a spontaneous menopause five years previously. Her menstrual history was not remarkable. Papanicolaou smear two weeks prior to admission showed "increased estrogenic-like effect with atypical cells."

Physical examination revealed an abdominal mass extending in the midline from the symphysis to six centimeters below the umbilicus. On pelvic examination there was evidence of blood coming from the cervical os. The uterus was 16-18 weeks in size and firm. A mass occupied the right and the left adnexa to the pelvic sidewalls.

One week after admission an examination under anesthesia and a dilatation and curettage were performed. The uterus was felt to contain an 18-week size multinodular myoma. There was still some question whether the patient had a pedunculated myoma extending to the pelvic sidewalls or whether there was an adnexal mass present. The endometrial curettings demonstrated hyperplasia of both the glandular and stromal elements but no anaplastic or dysplastic change.

Two weeks after admission, an exploratory laparotomy revealed a left ovarian solid tumor measur-

ing 6 x 8 x 8 cm. and an enlarged uterus with a subserous myoma. Frozen section of the left ovary was described as a Brenner tumor. A total abdominal hysterectomy and bilateral salpingo-oophorectomy were then performed without complication. The post-operative course was unremarkable and the patient was discharged seven days after surgery.

Macroscopic Findings

Macroscopic findings: The uterus, measuring 9 x 6 cm. contained a large intramural leiomyoma which was located near the lower uterine segment. Both fallopian tubes were unremarkable. The left ovary contained a solid ovarian mass which measured 7 x 5 x 3 cm. Serial sections through the tumor revealed a homogeneous, slightly lobulated interior which was light yellowish-tan in color. The right ovary measured 3 cm. in greatest diameter. In one pole of the ovary was a discrete rounded tumor measuring 1.3 cm. in diameter, which had a homogeneous grayish yellow interior, much like that of the left.

Microscopic findings: The endometrium demonstrated glandular hyperplasia interspersed with areas of hemorrhage secondary to the previous endometrial curettage (Figure 2). The vaginal mucosa was not atrophic but appeared as if it had been in-

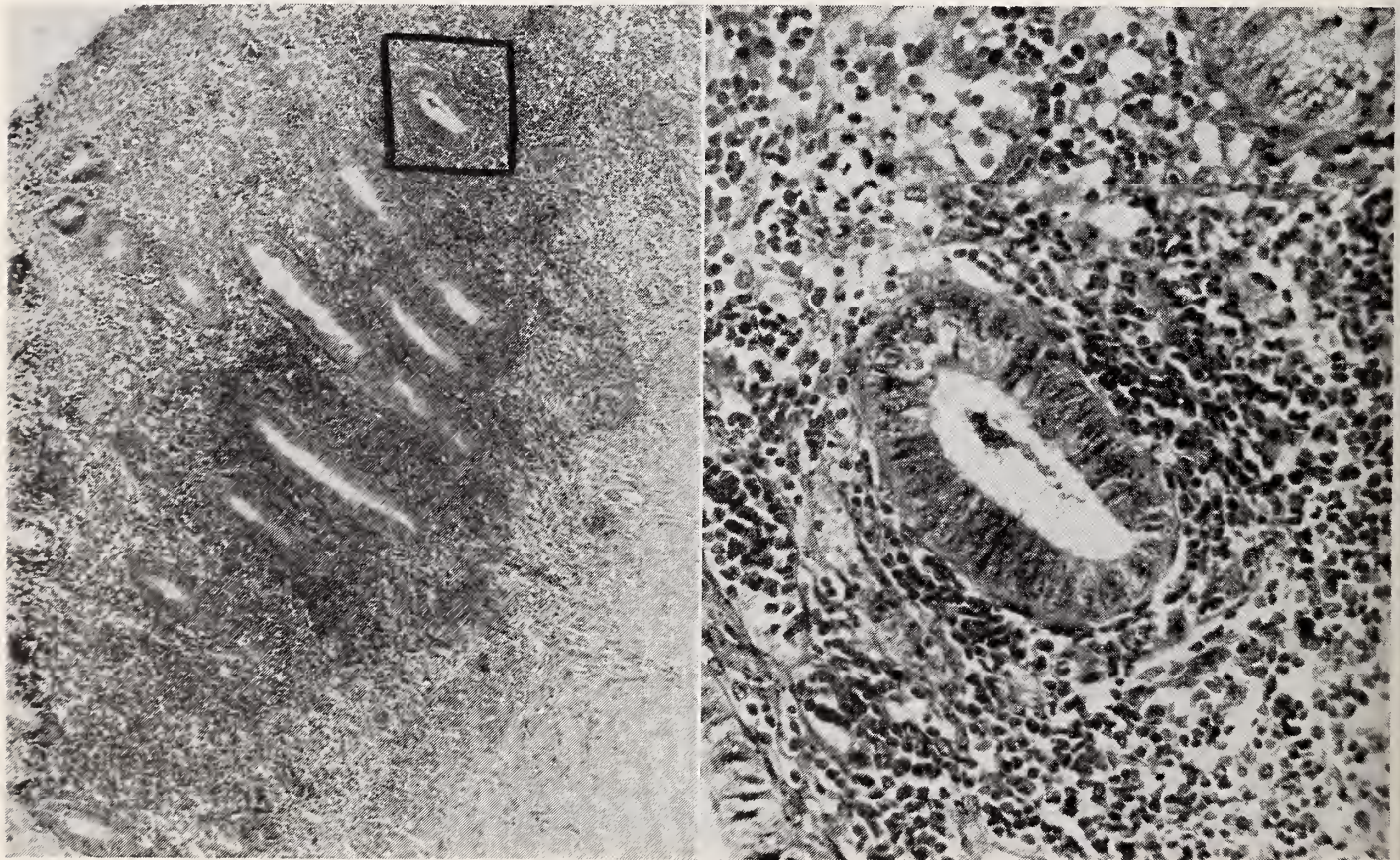


FIGURE 2

Endometrium from patient W.M. Note the hyperplastic endometrial glands in (a) ($\times 100$, H&E); 2b is greater magnification of enclosed area in 2a ($\times 1000$, H&E).



FIGURE 3

Vaginal mucosa from patient W.M. which demonstrates thickened epithelial cells with abundant presence of glycogen. ($\times 100$, H&E).

fluenced by an estrogen-like substance (Figure 3).

The descriptions of both Brenner tumors are similar to those of the other case. The larger tumor in the left ovary contained more numerous compact epithelial cell nests with occasionally vacuolated cytoplasm. The right ovarian tumor contained fewer of those elements already mentioned to be present on the left. Both tumors appeared to be benign.

Analysis of Cases

Age: Of the 25 cases, ten (40 per cent) occurred after the age of 51 years; nine (36 per cent) from 41-50 years of age; six (24 per cent) from 31-40 years of age; and none under 30 years of age.

Parity: Of the 18 cases in which parity was stated, the number of children ranged from zero to four with an average of 1.83 per woman. For all cases, regardless of menopausal status, the incidence of abortions per pregnancy was 31 per cent (in 35 pregnancies). The abortion incidence may be subdivided as follows: definite and presumed premenopausal—21 per cent (in 20 pregnancies); definite and presumed postmenopausal—47 per cent (in 15 pregnancies).

Menopausal status: In seven cases the menopause was definitely stated; in six cases menstrual activity was still present. Three cases were older than 61 years of age and presumed to be menopausal; four cases were younger than 41 years of age and were presumed to be premenopausal. Thus, the incidence of bilateral tumors both in menopausal and in pre-menopausal cases appears to be

50 per cent. The average age for the established menopausal cases was 61.8 years and that of the established pre-menopausal cases was 42.8 years.

Symptoms: The most frequent symptom was abnormal bleeding (six cases). Abdominal pain was present in five cases; abdominal mass in three cases and pelvic pressure in three cases. There were no gynecological symptoms in four cases. No symptoms were given in three cases.

Uterine pathology: Eighteen reports gave information regarding the status of the uterus. Eleven cases (61.1 per cent) showed fibromyomata. Polyps were present in one case (5.5 per cent). The endometrium was described as hyperplastic in three cases (16.7 per cent), proliferative in one case (5.5 per cent), secretory in one case (5.5 per cent) and atrophic in one case (5.5 per cent). In the five postmenopausal cases, both definite and presumed, in which the endometrium was described, three reports showed endometrial activity and two were inactive. Adenomyosis was present in one case (5.5 per cent). The uterus was described as not remarkable in two cases.

Ovarian pathology: The largest tumor was 18 x 10 x 9 cm. and the smallest was microscopic. The larger of the bilateral tumors occurred in the left ovary in twelve cases (48 per cent) and in the right ovary in seven cases (28 per cent). In one case (4 per cent) the tumors were approximately equal in size. Five cases did not specify laterality when stating the tumor dimensions. Malignancy was diagnosed in one case (4 per cent).

Comment

The occurrence of bilateral Brenner tumors presents an interesting phenomenon. These tumors may arise simultaneously in each ovary with the variation in size of tumor being explained by simple biological variability. On the other hand, a Brenner tumor may initially arise in one ovary and then at a later date, by some undetermined mechanism, a similar tumor may occur in the contralateral ovary. Either possibility suggests a more active process of tumorigenesis in bilateral tumors than in unilateral tumors; hence, a comparison of the clinical and pathological aspects of bilateral Brenner tumors with those of unilateral Brenner tumors is of interest.

Importance of Age

Table 2 lists the age incidences for unilateral and bilateral Brenner tumors. The unilateral tumor occurs with approximately the same frequency before (49 per cent) and after (51 per cent) the age of 50 years. On the other hand, bilateral tumors have a slightly greater incidence (60 per cent) before

TABLE 2
AGE INCIDENCE OF BRENNER TUMORS

	Bilateral Tumors (Present Study)	Jondahl et al. ⁵	Unilateral Tumors Woodruff and Acosta ³¹	Fox ²	Average of 3 Reviews
Number of cases	25	31	90	124	—
Age					
Under 40 yrs.	25%	10%	29%	21%	20%
40-50 yrs.	35%	30%	32%	26%	29%
Over 50 yrs.	40%	60%	39%	53%	51%

50 years of age than after (40 per cent). This difference in the age occurrence between unilateral and bilateral tumors is statistically significant (Chi square = 132; $p < 0.0005$). One must, however, keep in mind the disparity in number between the two samples (unilateral = 245 cases; bilateral = 25 cases). Although not marked, there is a trend suggesting that bilateral Brenner tumors occur earlier in life than unilateral Brenner tumors.

Previous reviews of unilateral tumors^{5, 30} have shown that 68 per cent and 70 per cent of patients, respectively, were para 2 or greater, as compared to this study where only 50 per cent of cases had 2 or more children with 33 per cent of cases being multiparous. This difference is statistically significant (Chi square = 37; $p < 0.0005$). For those bilateral Brenner tumor patients who have passed the menopause, the abortion incidence is 47 per cent, being considerably higher than the 14 per cent and 15 per cent incidence of abortion found in patients presumably without gynecologic disease.^{31, 32} Although there are no similar statistics for abortions in unilateral tumors, it appears that patients with bilateral Brenner tumors have a relatively poorer reproductive performance than patients with only unilateral Brenner tumors.

In regard to symptomatology, bilateral Brenner tumors fail to evoke any characteristic complaints which cannot be found in unilateral tumors.^{5, 12, 30} These symptoms, in both cases, include abnormal uterine bleeding, an abdominal mass, abdominal pain, and lower abdominal pressure.

Predominance in the right or left ovary does not appear to be a feature of Brenner tumors. Unilateral tumors occur with approximately an equal frequency on each side.^{2, 5} In the case of bilateral tumors, the larger of the two neoplasms did not predominate in either ovary. Christren and Janovski²⁶ suggested that the older of the bilateral Brenner tumors is comprised of more nests of epithelial cells whose cytoplasm demonstrates coarser granules and in-

creased vacuolization. According to these histologic criteria, the older tumor was also the larger in their report, as well as in the present report.

Low Incidence of Malignancy

The incidence of malignancy in all Brenner tumors is considered low, being estimated by Idelson to be about 5 per cent of cases.¹² Woodruff and Acosta's series of 90 unilateral tumors demonstrated a 9 per cent malignancy rate which is slightly higher than the 5 per cent incidence found in this review of bilateral tumors. There is a possibility that bilateral tumors, by manifesting at a younger age, produce enough symptomatology to bring the patient to laparotomy sooner than with unilaterals. Consequently, the early removal of these neoplasms which may be capable of future malignant change, could explain the lower malignancy rate in bilateral tumors.

Possible Estrogen Production

Although not conclusive, there is evidence which suggests that some Brenner tumors are capable of producing an estrogen-like substance. In this study, three (60 per cent) of the five postmenopausally occurring cases of bilateral Brenner tumors demonstrated an increased endometrial activity which was also present in 75 per cent of cases in Ming and Goldman's review of 66 postmenopausal patients with unilateral Brenner tumors.²⁹ Such endometrial changes may indicate an increased hormonal activity, presumably originating from the ovaries. Shaa-ban³³ reported increased urinary estrogen levels five weeks post-operatively in a postmenopausal patient with a unilateral Brenner tumor. Even though no pre-operative urinary estrogen levels were determined, this author felt these elevated levels to be the result of a functioning ovarian Brenner tumor.

Summary

Two cases of bilateral Brenner tumors of the ovary in postmenopausal women are herein reported. This

brings the total of bilateral Brenner tumors reported to 37. The case histories of 25 bilateral Brenner tumors have been reviewed and analyzed. In contrast to the unilateral tumors, it appears that bilateral tumors occur at a slightly earlier age, are associated with lower parity and higher abortion incidence, and

have a lower rate of malignancy. On the other hand, unilateral and bilateral Brenner tumors are similar in terms of symptomatology, laterality of tumor size and postmenopausally associated endometrial activity.

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OBSTETRICIANS-GYNECOLOGISTS TO MEET APRIL 28-MAY 1

The 17th Annual Clinical Meeting of the American College of Obstetricians and Gynecologists will be held at the Americana Hotel in Bal Harbour, Florida, April 28-May 1, 1969. Twelve postgraduate courses will be conducted immediately prior to the meeting on April 26 and 27.

Both the clinical meeting and the postgraduate courses are open to all physicians regardless of specialty, and the college invites them to attend. Registration fee for physicians who are not members of the college is \$50 for the clinical meeting and is \$45 for the postgraduate courses.

During the meeting, virtually every major obstetric-gynecologic topic will receive attention via formal

papers, colloquia, panel discussions, correlated seminars, luncheon and breakfast conferences, and reports on current investigations. In addition, there will be a showing of new motion pictures pertaining to the specialty, as well as 250 scientific and industrial exhibits.

Some 500 nationally eminent physicians, most of whom are fellows of the college, will present the program. Approximately 3,000 physicians are expected to attend the meeting.

For complete information about the meeting and/or postgraduate courses, physicians should contact the Meeting Services Department of the College, 79 West Monroe, Chicago, Illinois 60603.

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Coronary Arteriography

HARVEY G. KEMP* and RICHARD GORLIN,† Boston, Massachusetts

OPACIFICATION OF THE coronary vascular system by contrast material during cardiac catheterization has had an enormous impact on our knowledge of coronary heart disease. It has allowed us, with surprising safety, to define precisely the anatomic extent of coronary atherosclerosis in living man. Added impetus has been given to coronary arteriography by new directions in therapy. For example, there is accumulating evidence that surgical revascularization of the myocardium is not only feasible but beneficial. The normal course of a recently developed diagnostic procedure, like a new drug, is to oscillate between crests of over-enthusiasm and nadirs of total rejection. Now, after some ten years, it is useful to reassess the place of coronary arteriography in the diagnostic armamentarium.

General Review Given

Because this article is intended to give a general view of the field to the practicing internist, surgeon, and general practitioner, relatively little attention will be given to the technical details of obtaining high quality coronary arteriography. It will be repeatedly stressed, however, that only high quality studies provide the accurate information which justifies exposing the patient to the potential hazards of the procedure.

The two methods which have received widest application are the retrograde approach from the right brachial artery and the percutaneous retrograde approach from the femoral artery using a pre-formed catheter. In experienced hands, either

of these methods can yield excellent selective studies, at low risk to the patient.

Evaluation of Hazards

The decision to perform coronary arteriography should be based upon the weighing of the benefits expected to accrue from the resulting information, as opposed to the potential hazards involved. The latter have recently been evaluated in a co-operative study of 16 laboratories. A total of 3,312 studies performed on 3,264 patients were included in the study group. Sixty-six complications occurred in 62 patients, for an overall complication rate of 1.9 per cent. Cardiac complications occurred in ten: myocardial infarction in five, coronary insufficiency in four, and dissection of a coronary arterial wall without myocardial infarction in one.

Low Mortality Rate

Death occurred in two of the five patients sustaining a myocardial infarction. One of these patients had an aortic valve replacement with a Starr-Edwards prosthesis, and the infarction was secondary to coronary embolism. An additional death occurred in a patient with combined coronary heart disease and aortic stenosis, yielding an overall mortality rate of less than 0.1 per cent.

Ventricular fibrillation occurred in 27 patients: It was found to be a more frequent complication in women, and occurred oftener after injection of the right than the left coronary artery. In each instance, the patient recovered without sequelae, indicating the relatively innocuous nature of this arrhythmia when well-trained personnel and adequate resuscitative equipment are available.

Thrombosis of the brachial artery occurred in ten patients, but in the present author's experience, this probably underestimates this complication. For-

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unately, if the brachial artery remains patent above the antecubital space, symptoms are slight and transient, and surgical repair is not necessary. However, surgical intervention has been necessary in about 0.5 per cent (2 of over 400) patients in the author's experience. In both instances, surgery restored the patency of the brachial artery.

Severity of Disease Is Important

It seems reasonable to conclude from available data that the risk of death related to coronary arteriography is related to the severity of the coronary heart disease, and that significant aortic stenosis or prosthetic replacement of the aortic valve adds to that risk. On the other hand, the vast majority of patients undergoing this procedure have extensive coronary disease and withstand the arteriographic study with no complication at all.

It is somewhat easier to quantify the potential hazards associated with coronary arteriography than to assess the potential benefit to the individual patient obtained from the information yielded by the procedure.

It is safe to generalize that the physician caring for a patient is always better equipped to do so when his knowledge of the patient's condition is extended. This is particularly true of diseases in which there is relatively poor correlation between symptoms, indirect measurements, and the extent of anatomic disease. In this regard, several specific observations about coronary heart disease have emphasized the usefulness of arteriography.

Paradoxical Syndrome

Studies in the past based solely on autopsy material had shown an excellent correlation between a clinical history of angina pectoris and extensive coronary atherosclerosis. Since the advent of coronary arteriography, however, a group of patients has emerged with angina pectoris but whose major coronary arteries are free of intraluminal obstruction. The incidence of this paradoxical syndrome has been consistently reported to be about 10 per cent of subjects referred to centers performing coronary arteriography because of angina pectoris. The etiology of angina in this group remains obscure, but it would seem probable that the appropriate treatment and prognosis of this group will prove to be significantly different from their counterparts with arteriographically demonstrable coronary atherosclerosis. At present, there are no methods other than arteriography to differentiate these two groups.

Inconclusive Clinical Evidence

In addition to the unusual syndrome just described, there are many patients with less typical

histories, with non-specific electrocardiographic abnormalities, with unexplained congestive heart failure, arrhythmia or some combination of the above, in whom coronary heart disease is suspected but cannot be included or excluded on clinical grounds alone. An unknown, but certainly high, percentage of these patients will have normal coronary arteriograms and treatment can be redirected, either toward correction of whatever disease is found, or, in the absence of demonstrable heart disease, toward psychologic rehabilitation. The amount of psychologic damage done to patients by well-intentioned physicians who have erroneously attached the label of coronary heart disease to some masquerading symptom complex, can neither be overestimated nor readily undone.

Most Frequent Indications

Perhaps the largest group of patients who merit coronary arteriographic studies includes those who have clearly established coronary heart disease associated with chest pain syndromes not easily controlled by medical management. It is obvious that several value judgments are called for in including the individual patient in this group, and that probably no two observers would consistently evaluate the same patient in exactly the same fashion. Also, it is clear that while the results of myocardial revascularization are being more precisely defined in terms of pain relief, objective signs of increased myocardial perfusion, and longevity, our criteria for study will continue to change.

Although it is not within the scope of this report to evaluate critically the status of myocardial revascularization, the threshold for a decision to obtain arteriographic studies is inextricably related to one's evaluation of the benefits potentially available through surgical intervention. Addressing ourselves to this specific point, the authors believe that present data strongly indicate that not only can pain syndromes be substantially relieved by internal mammary artery implantation, but that there is objective evidence of improved myocardial perfusion, and further, that there is reason for optimism concerning improvement in longevity, particularly in patients surviving 18 months after the procedure.

New Procedures Show Promise

In addition, new revascularization procedures, particularly the direct replacement of segments of the right coronary artery with venous grafts, currently show promise. As surgical procedures have continued to evolve, young patients with myocardial infarction without pain or congestive heart failure have become legitimate subjects for arteriography, at least in centers where data concerning the effect

ARTERIOGRAPHY / Kemp, Gorlin

of revascularization on longevity are being actively accrued and evaluated. For the present, it seems unwise and overly conservative to allow patients to restrict their lives severely because of coronary heart disease, and this is particularly true of the young patient.

Miscellaneous Indications

There are a number of miscellaneous indications for coronary arteriography. Patients with angina and aortic valve disease being considered for valvular replacement should certainly be studied and probably patients with mitral valve disease as well. This enables the cardiologist to understand better total myocardial function and make a more objective estimate of surgical risk and ultimate prognosis. It provides very helpful information for the surgeons who will be perfusing the coronaries at the time of surgery. Uncommon specific indications for coronary arteriography include suspected congenital malformations, luetic involvement of the coronary ostia, and coronary artery embolism.

To some degree, the indication for adding selective coronary arteriography to any retrograde left heart catheterization procedure performed on a patient in the coronary age group depends upon the ease with which the particular laboratory can perform coronary arteriography. If experienced personnel are available, it can add very helpful information at a negligible additional risk to the patient.

Left heart catheterization of a patient with suspected cardiomyopathy is an excellent case in point.

Accuracy of Coronary Arteriography

Every diagnostic procedure must be evaluated in the light of the accuracy of the information it yields. When one views coronary arteriography of excellent radiographic quality, a highly accurate picture of the major coronary vessels and their branches has been obtained. A study comparing the interpretation of coronary arteriography with the actual amount of disease found at necropsy done on 29 subjects at the Peter Bent Brigham Hospital confirmed this impression. Of the many opportunities for error in interpreting 145 coronary arteries individually, only three errors of functional significance were made. There was a direct relationship between the accuracy of interpretation and the radiographic quality of the arteriography, significant errors being made only in films of borderline quality.

Technical Factors

A number of factors contribute to radiographic quality, most of which are of a technical nature and are not germane to the present discussion. It is sufficient to remember that appropriate magnification, contrast, focus, and day-to-day consistency are essential and most often found in a laboratory with a high degree of interest in an almost daily use of coronary arteriography.

Boston, Massachusetts

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The Efficacy of Clindamycin in Beta-Hemolytic Streptococcal Infections of the Upper Respiratory Tract

JEROME D. BERMAN, M.D. *and* MICHAEL K. LEVINE, M.D., *Atlanta*

THIS PAPER REPORTS on a study conducted to determine the safety and efficacy of a new antibiotic, clindamycin (Dalacin C®). The study group consisted of 47 children with β -hemolytic-streptococcal infections including tonsillitis, pharyngitis and scarlet fever.

Clindamycin

Clindamycin is a new semi-synthetic antibiotic presently under clinical investigation. It is produced by a chemical substitution of the 7(R)-hydroxyl group of the parent compound lincomycin, by a 7-chloro substituent.¹ In vitro studies indicate that clindamycin has a high degree of activity against gram-positive organisms and a lower order of activity against gram-negative organisms. The spectrum of activity includes staphylococci (including penicillinase-producing strains), β -hemolytic streptococci, *Streptococcus viridans*, *Diplococcus pneumoniae*, *Clostridium tetani*, *Clostridium perfringens*, *Corynebacterium diphtheriae*, *Corynebacterium acnes*, *Bacteroides* sp., *Nocardia* sp., *Actinomyces israeli*, and *Mycoplasma pneumoniae*. In addition, some strains of *Hemophilus influenzae* and *Neisseria gonorrhoeae* are sensitive in vitro. Clindamycin is not active against most strains of *Streptococcus faecalis*, *Escherichia coli*, *Shigella* sp., *Salmonella* sp., *Proteus* sp., and *Pseudomonas* sp.

Rapidly Absorbed

Clindamycin is rapidly and almost completely (90 per cent) absorbed; peak serum levels, and levels in bone and in synovial fluid are reached within one hour. In one study² the peak serum ac-

tivity was found to be 45 minutes, and the half-life averaged 2.38 hours. Concomitant administration of food does not appreciably delay absorption,³ and serum levels are maintained above the minimum inhibitory concentration for most gram-positive organisms for at least six hours following the usually recommended doses.

Generally Well Tolerated

Clindamycin is generally well tolerated. Side effects, determined during the clinical investigation thus far conducted, were limited chiefly to gastrointestinal disturbances. The total side effects that were probably drug related in 851 patients studied were 2.6 per cent. The recommended dosage for adults is 600 to 1200 mg. per day in divided doses, depending on the severity of the infection.

Materials and Methods

The study group consisted of 47 children with β -hemolytic streptococcal infections proven by throat culture. The initial severity of infection and the

TABLE I

Type of Illness	Initial Severity			Total
	Mild	Moderate	Severe	
Pharyngitis	10	13	6	29 (62%)
Tonsillitis	2	9	1	12 (25%)
Scarlet fever	0	5	0	5 (11%)
Pharyngitis plus tonsillitis	0	1	0	1 (1%)
Total	12 (25%)	28 (60%)	7 (15%)	47

TABLE II				
Type of Illness	Initial Condition of Patient			Total
	Mild	Moderate	Severe	
Pharyngitis	12	16	1	29 (62%)
Tonsillitis	3	9	0	12 (25%)
Scarlet fever	0	5	0	5 (11%)
Pharyngitis plus tonsillitis	1	0	0	1 (1%)
Total	16 (34%)	30 (65%)	1 (1%)	47

initial condition of the patient are shown in Tables I and II. The age range was three to 14 years with a mean age of 7.5 and a median of eight. The body weights ranged from 28 to 134 pounds with a mean of 61.2 and a median of 58. There were 24 boys and 23 girls.

The dosage was either 75 mg. t.i.d. or 150 mg. t.i.d. depending on body weight. Thirty-seven children received the lower dosage and 10 the higher. The duration of therapy was 10 days for all. Before treatment and after treatment the following laboratory tests were performed: SGPT, alkaline phosphatase, hemoglobin, hematocrit, and WBC and differential. Throat cultures were performed on days 1, 4, 11, and 21 through 28. Sensitivity to clindamycin was determined pre- and post-treatment using a 2 mcg. disc. In addition, the number of days of fever was recorded for all patients.

Results From Test Group

The response by condition is shown in Table III. It can be seen that the clinical cure rate (disregarding asymptomatic relapse) is 98 per cent and the over-all cure rate is 89 per cent. All of the offending organisms were sensitive to clindamycin.

The results of the laboratory tests are shown in Table IV. The rise in the mean SGPT requires some explanation. If ≤ 40 is assumed to be "normal," then two of the 47 patients were abnormal before therapy. After therapy there were three abnormal,

one of them was abnormal before therapy and two became abnormal after therapy. The latter two had readings of 66 and 44, not excessively higher than normal. Thus there is little to suggest a clinically meaningful shift in SGPT related to therapy, although there was a statistically significant rise in the group mean SGPT after treatment.

As shown in Table IV, the WBC and the differential showed the typical changes. The monocytes, eosinophils and basophils were all within normal ranges, and are not shown. Twenty-four children did not have fever following therapy, 21 had one day of fever, and two had two days. There were no side effects reported.

Discussion and Summary

Prior to this study we used either erythromycin or penicillin for β-hemolytic streptococcal infections of the upper respiratory tract. While this study group was small and there were no controls, we were sufficiently impressed by the results to consider clindamycin as an effective replacement for penicillin or erythromycin. This conclusion is based on the fact that the response was excellent, but even more important, there were no side reactions. The laboratory tests were within normal limits at the conclusion of therapy with the exception of the transaminase test which we do not feel is clinically significant. Further studies currently being conducted by our group and others are needed to confirm this conclusion.

On the basis of an open label study of 47 chil-

TABLE IV			
	No.	Mean Pre-Rx	Mean Post-Rx
SGPT	47	12.7	17.9
Alkaline phosphatase	47	26.3	26.6
Hemoglobin	43	12.98	12.88
Hematocrit	43	39.00	38.33
WBC	47	11,791	8,642
Neutrophils	47	79.51	65.02
Lymphocytes	47	18.11	32.49

TABLE III				
Type of Illness	N	Asymptomatic Relapse by Throat Culture	Symptomatic Relapse	Total Relapse
Pharyngitis	29	3	0	3 (10%)
Tonsillitis	12	1	1	2 (17%)
Scarlet fever	5	0	0	0 (0%)
Tonsillitis plus pharyngitis	1	0	0	0 (0%)
Overall total	47	4	1	5 (11%)

dren with proven β -hemolytic streptococcal infections of the upper respiratory tract, clindamycin was found to be an effective and safe antibiotic.

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6363 Roswell Rd., N.E.

90 Years Ago

Traumatic Tetanus

BY A. R. TAYLOR, M.D., HAWKINSVILLE

On the sixth of July last I was called in haste to see a little girl, aged seven years, whom the parents, at the time, thought was dying. When I arrived at the house, I learned the history of the case. Two days previous the little girl, while playing in the yard, (being bare-footed) accidentally hurt her foot by striking it against the sharp edge of a light-wood stump, thereby inflicting a severe wound at the base of the great toe, leaving a splinter firmly imbedded in the tissues. Her parents extracted the most of the splinter and then bound the foot in a cloth saturated with spirits of turpentine, and used some other domestic remedies. Thinking the wound was not serious, the child was allowed to go about as usual.

Nothing noticeable happened until the 15th, when the child complained of a tingling sensation in the wounded foot and leg, with some stiffness of the jaws and a feeling of weariness and general lassitude, with slight fever, for which she was given a cathartic and a warm bath. She rested well during the night, and it was not until the morning of the 16th that her parents became alarmed and requested me to see her. When I first saw the girl I found the jaws firmly locked and the head forcibly drawn back with tonic rigidity of the muscles of the upper and lower extremities and an inability to swallow.

This paroxysm lasted only a few minutes and then gradually passed off, after which she complained of pain at every effort to open her mouth widely, and a cramping sensation during deglutition.

From her previous history and the symptoms present, I had no trouble of making this out a case of *traumatic tetanus*.

Having seen but one other case of this kind in my practice, which died, although I had treated it as recommended by the best authors on this particular disease, I now felt sure that this little girl of seven years of age, who was already very much debilitated by previous sickness, would certainly succumb.

Tetanus is one of those diseases which has occupied the attention of authors who have not arrived at any sound conclusions, and the theories that have been

advanced, after careful and laborious investigations, are as unsatisfactory as are the numerous remedies that have been proposed for its cure. The catalogue of medicines employed at various times and in different cases for its cure are quite numerous, and embraces everything that the most acute and active intellect could suggest, and there are cases on record where the patients, left to themselves, have recovered. So in this case I was at a loss to know what particular treatment to pursue. Having used chloral hydrate in several nervous diseases, also in epilepsy, infantile convulsions and other kindred troubles, I was induced to give it a trial in this case, in conjunction with calabar bean. The intervals of the paroxysms were at first from two to three hours, consequently I had ample time to try the efficiency of the medicines. I commenced the chloral in ten grain doses with mucilage of gum, and repeated every half hour until four such doses were taken, and then increased to twenty grains every hour. The first dose caused considerable trouble in the attempt to swallow—the liquid passing out through the nose—yet, by a strenuous effort, the child took the second dose tolerably well, and each subsequent dose was taken more readily. I gave the calabar bean in powders, mixed with gum syrup, every four hours, commencing with one grain doses and gradually increased to three grains until the system became relaxed, and then I reduced back to one grain, to be continued every six hours. I laid open the wound of the foot and extracted the balance of the splinter, and applied warm hop poultices continually, with ice bags to the spine, with quinine and brandy given in small portions during the day. I was enabled to shorten the paroxysms with chloroform by inhalation. Under this treatment my little patient gradually recovered, and is now in perfect health. The wound suppurated for several days and then healed by granulations.

I report this case to the Medical Association in order to get their views relative to the use of chloral and calabar bean in the treatment of *tetanus*, and more especially the calabar bean in such large doses as I gave my little seven year old patient. I hope to get your experiences during the meeting of the Association in regard to this terrible disease.

From Transactions of the Medical Association of Georgia, Thirtieth Annual Session, Rome, April 16-18, 1879.

In the 50 previously reported cases in the world literature, maternal mortality has been 13 per cent, while the fetal death rate has been about 50 per cent.

Hematoma of the Rectus Abdominis Muscle in Pregnancy, Labor or Puerperium: Report of 3 Cases

RICHARD TORPIN, M.D.,* *Augusta*, JOHN COLEMAN, M.D., B.Ch. (Cantab),† *and*
JOHN R. HANKINS, M.D.,** *Shiraz, Iran*

IN 1923 THOMAS CULLEN and Max Brodel¹ produced a masterly description of the rectus abdominis muscle, structure and blood supply. One of its characteristics is a rare tendency to rupture of a vessel and the subsequent production of a hematoma within the muscle sheath. Infrequently the sheath ruptures and hemorrhage extends. This small group constitutes the ones most likely to be fatal.

Etiologic factors include trauma in newly recruited soldiers, in athletes and strain of coughing or strain of labor in pregnant women. There may be a special tendency to muscle degeneration in typhoid fever and in influenza. In 1950 Savitsky and Karl-ner² reported a case occurring after electroshock therapy in which one pint of blood was found at operation.

A case occurring in late pregnancy was observed by one of us (RT) in 1937 and it was associated with strain produced by coughing. The world's literature was collected and in 1943 twenty-seven cases associated with pregnancy were reported.³ The two significant causative factors in this group were trauma of coughing and strain of labor in the order stated.

Few References in Literature

While the library facilities are limited in Shiraz, a review of a dozen volumes of *American Journal of Obstetrics and Gynecology* preceding the present date (1960), and the last five volumes of the *Year Book of Obstetrics and Gynecology*, and many,

but not all, bound volumes of the *Journal of the American Medical Association*, revealed only three references to this condition.

One was an abstract of a report by Rufus C. Thomas³ in 1945. He stated that there were 31 cases previously noted, with correct preoperative diagnosis in only nine, and a maternal mortality of 13 per cent and fetal mortality of 50 per cent. His patient was 33 weeks pregnant and developed bronchitis with coughing. The lesion was in the right rectus muscle and the diagnosis was concealed hemorrhage. There was found, at operation, a rupture of a branch of the deep epigastric artery and of another smaller vessel. Five days postoperatively she delivered a stillborn infant.

J. A. Chalmers, in 1950,⁴ apparently reviewed the literature and stated that to that time there were 45 cases associated with pregnancy, and he added four more instances. In one of the four, the most serious, the clot was surgically evacuated. In the other three non-operative treatment resulted in spontaneous absorption of the clot. There was no maternal mortality but one fetus died in utero.

The three cases here reported occurred, two in the Christian Mission Hospital (Anglican), and one in the Nemazee Hospital. The first two instances are typical while the third occurred possibly at the time of labor or certainly in the early puerperium.

First Case

Case I, R.K., medium constitutional type Iranian woman, 22 years of age was in her fourth pregnancy with three living children. At seven months of preg-

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nancy she was admitted to the Christian Mission Hospital, January 8, 1959, in very poor condition, practically in surgical shock. The nurse records her as "looking terrible." The history of the illness indicated that one month previously, along with severe coughing she noted sudden intense pain in the region of the left rectus muscle. There also was localized swelling in this region. On the third hospital day there began to appear ecchymosis to the midline and around the umbilicus.

Fetal Heart Tones Normal

The mass was evidently in the abdominal wall on the left of the umbilicus and oval in shape along the course of the rectus sheath. It was approximately 10 cm. long and 8 cm. wide and very tender. The seven month pregnant uterus contained a fetus whose heart tones were normal. She was again seen on January 27 when the size of the hematoma was much the same but the tenderness was less. Her rather meager laboratory studies all were negative except for some degree of secondary anemia, and she was seen in consultation by James A. Halsted, M.D., from the Medical Department of Nemazee Hospital, who concurred on the diagnosis. She left the hospital and in spite of frequent search in the intervening year, no further record of her has been found. This search was carried out by all of the midwives, public health services and inquiries in all of the hospitals. The search was rather intense since a liberal reward was offered for any information. In addition, her name did not appear in the death records which seem to be well kept.

Case II, M.S., medium constitutional type Iranian woman, aged 34, entered the Christian Mission Hospital near term in her tenth pregnancy. She had eight living children, the first having been stillborn at eight months of pregnancy. Several days before she had developed a great deal of coughing and the day before admission had suddenly noted severe pain in the left rectus area and swelling at that site. On the second day of hospitalization she went into labor and at the end of seven and a half hours delivered a living female infant weighing six and a half pounds. The placenta and membranes were complete and there was no more than usual blood loss. The infant was depressed but lived.

Extreme Pain During Labor

During labor she had exquisite pain in the region of the mass. Nine days later the mass lay on the level or slightly higher than the umbilicus and external measurements were approximately 10 x 14 cm. with an estimated thickness of 2 cm. (Fig. I). Four days later the R.B.C. count was 3,500,000 with hemoglobin—73 per cent. The following day



FIGURE 1

Two views of the abdominal contour of patient M.S. in Case 2.

R.B.C. was 2,330,000 with hemoglobin—68 per cent. On this date ecchymosis appeared in the midline above and below the umbilicus. Three days later the hematoma had increased in size and was estimated to contain one pint of clot. Operation was advised but this she refused. She was again seen a month later and it was noted that the hematoma was absorbing well. Six weeks later it was nearly entirely absorbed and eleven months later there was no trace of any swelling found.

Case III, B.H., aged 38, slender constitutional type Iranian woman, gravida 7, para 6, all living, at eighth month of pregnancy, entered the Christian Mission Hospital because of profuse vaginal bleeding. She had premature labor and delivered spontaneously a live infant 3 pounds 4 ounces in weight which died 15 days later.

Post Partum Fever and Swelling

Soon post partum she began to have fever with swelling of the right groin region and of the right leg with diagnosis of thrombophlebitis. She improved under therapy and went home still with some fever. Forty days after delivery she began to have more fever, and swelling of the left leg. The pain increased in intensity for two weeks but on various

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types of treatment, outside, the pain and swelling were reduced.

She still had fever and swelling when she was admitted to the Nemazee Hospital two months after labor. There she was found to have edema, redness and tenderness of both lower extremities and a rather large mass in the lower left part of the abdomen. The hemoglobin was stated to be 9.5 gm.; W.B.C.—7000; coagulation time—four minutes; prothrombin time of patient—twelve seconds; and of control—twelve seconds—(100 per cent). She was treated by dicumeral and heparin because of the thrombophlebitis. Not much attention was paid to the abdominal tumor since it did not produce much pain. Three days after beginning of anticoagulant therapy her prothrombin time was recorded as 64 seconds with control 13 seconds (5 per cent). At the end of 18 days there was gynecologic consultation which noted the abdominal tumor to be 6 x 7 cm. in the left suprapubic region and localized to the abdominal wall.

The gynecology consultant did not attempt diagnosis but referred her to surgery where the following conditions were suggested: desmoid or other tumor of the rectus muscle, including organizing hematoma, cold abscess or other types of tuberculosis, hydatid cyst, chronic broad ligament or parametrial process pointing superficially, or a malignant intraperitoneal tumor invading the abdominal wall. A couple of weeks were allowed for the blood coagulability to return to normal and then exploratory biopsy operation was done.

Tumor Exposed

On exposure of the rectus muscle there was found a thick tumor-like bulging mass measuring 3 x 3 x 4 cm. in the rectus fibers. This was limited to the abdominal wall. The tumor was incised and old clotted blood found and evacuated. The clot was sterile on culture. Convalescence was fairly smooth, with one flair up of fever on the seventh day, and she was allowed home on the 16th day postoperatively. She has been seen recently, nearly one year after operation. The history obtained then could elicit no definite time of onset of the swelling, but it is known that the mass was present when she entered the Nemazee Hospital, and before she had had anticoagulant therapy. Inasmuch as the hematoma was not very large it may have caused little pain in relation to that in her legs due to thrombophlebitis.

The discovery of three cases of hematoma of the rectus abdominis muscle in pregnancy, labor or

puerperium in this region in 18 months time seems to be at variance with the incidence of placenta previa, premature separation of the normally implanted placenta, or of ectopic pregnancy and severe post partum hemorrhage, all of which hemorrhagic conditions appear to be reduced in incidence among the 17,000 pregnancies annually within 60 km. of Shiraz.

Diagnostic Criteria

Listed are the diagnostic criteria of hematoma of the rectus abdominis muscle:

- (1) Sudden onset in association with some degree of trauma of strain or of severe coughing.
- (2) Absence of signs of peritoneal or pelvic lesions usually eliminated by physical examination including vaginal examination.
- (3) Its apparent limitation to the abdominal wall. Lateral x-ray might help.
- (4) Almost pathognomonic is development of ecchymosis in the neighborhood usually to the midline.
- (5) Probably the most important diagnostic point is to have the possibility of the lesion in mind.

Summary

Three cases of hematoma of the rectus abdominis muscle in pregnancy, labor or the puerperium have been reviewed. In the 50 instances in the world's literature the maternal mortality has been upwards of 13 per cent while the fetal death rate has been approximately 50 per cent.

The diagnostic criteria have been listed.

This serious but uncommon lesion usually has a distinctive history of sudden onset with some degree of trauma, strain of coughing or strain of labor. The course of the disease with the appearance of ecchymosis, to the midline of the abdominal wall, helps to make the diagnosis, but the most important factor lies in keeping in mind the possibility of this condition in the differential diagnosis of acute abdominal disorders.

Medical College of Georgia

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Report on the Third Bi-Annual MAG Conference on Medical Education

THE THIRD BI-ANNUAL MAG Conference on Medical Education was held at Callaway Gardens on February 28, March 1 and 2, 1969. The usual and expected fruitful interchange of ideas and concerns took place among the faculty of our two medical schools and a group of practicing physicians from over the State. Subjects for discussion included the following topics: (1) Problems and Examination of Physicians; (2) Continuing Medical and Allied Health Education; (3) Training and Utilization of Allied Health Personnel.

Adding greatly to the depth and extent of our remarks were the resource people invited to participate. They included, respectively, John P. Hubbard, M.D., President of the National Board of Medical Examiners; Ralph Kuhli, MPH, Director of the AMA Department of Allied Health Education and Services; Darrel J. Mase, Ph.D., Dean of the College of Allied Health Professions at the University of Florida, and immediate Past-President of the Association of Schools of Allied Health Professions. A summary of the various discussions is included for your perusal.

Besides the interest generated by these matters, members of the Curriculum Committees from the Medical College of Georgia and Emory University School of Medicine presented their exciting new concepts of basic Medical Education as it is being developed within Georgia. These, too, are included in this issue of the JMAG for your study. Comments from readers will be welcomed at the MAG headquarters office, or at the two medical schools.

*John Rhodes Haverty, M.D.
Dean, School of Allied Health Sciences
Georgia State College*

A. Licensure Problems and Examination of Physicians

*Arthur Richardson, M.D., Moderator
John P. Hubbard, M.D., Resource*

The section on licensure and examination raised many questions. Repetition of questions asked by

the three groups highlighted both their validity and the shared concern of medical educators for these matters.

FLEX Examination

Greatest discussion centered on the National Board and FLEX examinations. The FLEX exam, as explained by Dr. Hubbard, is an examination developed by the Federation of State Licensing Boards and is an attempt at achieving uniformity in testing candidates for licensure by the various States. FLEX gives greater weight to the testing of clinical competency, whereas the National Board is designed to test what students are being taught. The Federation will grade the examinations uniformly throughout the country, but the States will determine for themselves the passing grade. The FLEX exam, which consists of three parts—basic science, traditional clinical subjects and testing of clinical competency—emerged primarily as the result of the disparity of licensure examinations given by the various States.

The Federation will keep on file the true scores made by each examinee. States will adjust the true score to determine passing grades for their State. Thus, in matters relating to reciprocity, the true scores may be determined. The view was expressed that different adjustments of the true score by the various States is likely to result in reciprocity problems.

The most frequent question concerned the necessity for both the National Board and FLEX. It was pointed out that National Board is for the student of today and the physician of tomorrow; FLEX is for the student of yesterday and the physician of today. It was observed that in many respects National Board is becoming more of a service to schools by helping them locate weak spots in their program, and less of a licensure device.

Score Based on Total Exam

Concern was expressed that curriculum flexibility may result in a student's being weak in a particular subject contained in any national standardized examination. Dr. Hubbard explained that the Na-

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tional Board (and hence FLEX which uses National Board standards) is scored on the basis of the total examination and not on its separate parts. Accordingly, a student who may do poorly in a given subject due to minimum exposure would be expected to score heavily in other areas, reflecting the fact that he had concentrated more in other subjects, thus offsetting the lower grade.

Exempting State Graduates

Another view was expressed that perhaps graduates of Emory and the Medical College should not be required to take an examination for Georgia licensure. The point was stressed that the schools can best determine their student's ability to practice. Your moderator advanced the view that this would result in shifting the examination from the student to the school—that ultimately either the student or the school must be tested. Licensure by examination was said to have an historical significance dating to the early 1900's.

Citizenship as a condition of licensure was observed as an unnecessary requirement. The view was expressed that citizenship was a matter of concern for the Federal government, but that demonstrated qualifications to practice medicine should be the only concern of State government.

Additional comments were made from the floor following the above report: Licensing laws have not been the main pressure applied that has elevated standards of practice. Voluntary groups of doctors applying pressure on other doctors has been the principal lever.

Failure to take advantage of efforts to improve medicine could be detrimental to the practice. Efforts are needed to require physicians to continue to improve the practice. Hospital staffs may have to play a bigger part in seeing that continuing education is maintained.

B. Continuing Medical and Allied Health Education

J. Rhodes Haverty, M.D., Moderator
Mr. Ralph Kuhli, M.P.H., Resource

It seemed clear in all the discussion groups that a program of continuing education for all physicians is necessary. It was generally agreed that such continuing education *should* be mandatory, even though the unresolved problem of what action should be taken in the case of those who refuse this opportunity, may be sufficient reason for non-compulsion. Administration, supervision and record

keeping should be carried out by the MAG representing all physicians, with the providers of continuing education coming from the source of such knowledge, the medical schools, thereby preventing the necessity for provision or supervision by any outside agency.

What is desired by the physicians who will benefit should be determined by a study carried out by a subcommittee of the MAG. Generalized controls applied at the local level must be a part of the continuing education program, applied in such a way that participation is encouraged.

Effective, two-way communications entered our discussions, which indicated our concern in this area, and its importance in structuring an effective program. Time factors and accessibility are the roadblocks to be overcome in this particular effort.

Problem of Evaluation

Methods of evaluation present the greatest problem with the best answer being the results demonstrated by the practitioners. An intermediate step, however, could be a required response to courses in the form of reports submitted regularly for evaluation by all participants. The evaluation procedure will also indicate the desirable orientation for subsequent programing. Efforts should be made to eliminate the necessity of attending unneeded courses.

Education of Allied Personnel

Physicians should decide that they are going to take the responsibility for continuing education of allied health personnel, or they are going to relinquish completely that responsibility to the allied groups. This conference is of the opinion that we should assume that responsibility. The allied health personnel must provide for our patients what *we* think the patient needs, not what they think the patient needs.

Physicians should assist in drafting the allied health personnel programs and in designing the curricula so that both those seeking higher goals and those who have reached their goal, might be served.

In summary, even though these enumerated conclusions were reached in our discussions, one underlying tone remained—exhaust all voluntary approaches and utilize all voluntary methods, prior to making continuing medicine and allied medical education mandatory.

Additional comments were made from the floor following the above report:

Exams Are Inadequate

No examination has been devised that will test

adequately the ability to practice medicine, including the FLEX exam.

The test may result in giving too much control over practitioners without accomplishing much good. Continuing Education is a selling job. We must sell continuing education to practitioners before considering it on a mandatory basis. The type of medicine carried out by the doctors in the hospital makes the best criterion on which to judge the quality of medicine to be practiced, and putting all doctors on hospital staffs would be the best way to observe the quality of their practice.

Others in the group expressed the opposite opinion that we cannot rely on the hospital staffs to determine the quality of medicine practiced.

Allied health personnel should be limited only by their own limitations as far as training and their ability to perform. Of course, the final decisions regarding patient care should be made by the doctors.

The ability of the hospitals to oversee and improve medical practice through continuing medical education depends on the hospital. Some may be able to do it and some not.

It was stated that the delivery of continuing medical education should be the responsibility of the medical centers (Augusta and Atlanta). But others thought the process of learning must be made easy for the practitioners by taking the process to him.

C. Training and Utilization of Allied Health Personnel

Raymond C. Bard, Ph.D., Moderator

Darrel J. Mase, Ph.D., Dean, Resource

I. Basic Assumptions

A. Physicians need assistance in providing health care.

B. There are two categories of allied health professionals:

1. Those who require the supervision of a physician

2. Those who may work independently of the physician

C. Basic training programs are being shifted from hospitals to educational institutions.

II. Needs of Allied Health Education

A. Allied health professionals need the opportunity for career development.

B. College credit and "status" should be available to the middle level health person.

C. Common core curricula should be developed for allied health programs.

D. Clinical experience should be provided in hos-

pital settings, and other areas where patients are cared for.

E. Organized medicine should help determine needs and programs for training allied health professionals.

F. Who will provide the supervision and coordination of the health team? (An unanswered question.)

III. What next?

Organized medicine must play a leading role in determining what kinds of allied health people are needed and in what numbers and what kind of education and training they need. In Georgia most of these allied health programs are conducted in educational institutions under the control of the Board of Regents of the State Board of Education. These boards need guidance. Organized medicine can and should make an effort to provide it.

Producer-Consumer Cooperation

There is a need to get the producer of allied health professionals and the consumer of these people together for proper planning of programs and curricula. Organized medicine should make an effort to bring them together.

Because the nature of professional work changes so rapidly, it is imperative that continuing education be a part of the philosophy of the educational institutions. Students should be prepared to participate in continuing education programs during their productive years.

Additional comments were made from the floor following the above report:

One must remain alert to the possibility of someone in the allied health field aspiring to practice medicine. Failure of medical schools to teach students the limitations of supporting personnel and how to control and direct their activities could be a big mistake.

Curriculum Revision at the Medical College of Georgia

Phases I and II

S. A. Singal, M.D.

**Professor and Chairman (Acting)
of Biochemistry**

In the past few years the Faculty of the School of Medicine of the Medical College of Georgia has become concerned about its educational goals, concepts and methods. In a series of conferences and seminars, the educational program for the physician has been critically reexamined and reappraised, particularly as regards its relevance to the changing nature of medical practice, the variety of careers

ORGANIZATION OF NEW CURRICULUM FOR SCHOOL OF MEDICINE. MEDICAL COLLEGE OF GEORGIA				
Academic Year	Curricular Phase			
1	I	Molecular and Cell Biology	Human Biology	Elective
2	II	Biology of Disease		Elective
3, 4	III	Basic Clinical Experience Electives		
← 27 Wks. → ← 8 Wks. →				

in the medical profession and the needs of society for health care. It was repeatedly emphasized that the rapidly changing nature of medical and scientific information made it more important that our graduates be trained in the scientific method and adept at problem solving. It was less important that they all be presented with the same set body of facts in an identical and uniform fashion. This seemed especially important in view of the wide range of interests, aptitudes, abilities and attitudes of our incoming students.

Individualized Education

In order to provide this kind of educational environment, it was proposed that the Faculty study the possibility that more than one curriculum may be required; that through advanced placement techniques, wider use of electives and free time, and greater individual faculty-student contact, students may progress through their medical education in directions and at speeds that may vary with their individual abilities and goals.

It was recognized that this sort of approach would require careful supervision, a clear identification of a core of basic information and skills about which a more individualized program could be constructed. In addition, since each student's education would have to be well integrated and directed, it was recommended that study be given to the possibility of emphasizing the interdisciplinary approach to the curriculum.

The academic environment should emphasize the student's self-reliance and personal responsibility in learning, and place the faculty in the position of encouraging and facilitating this learning process.

Two Curricular Concepts

On the basis of these aims and objectives, a new curriculum was designed and developed by the Faculty. Its implementation began in 1967. The program is characterized by two curricular con-

cepts: the core curriculum and the elective program. The core curriculum is considered as providing the basic information and skills expected of all graduates, regardless of career objectives. It is presented to students as three distinct, but interrelated units: Molecular and Cell Biology and Human Biology in the first year (Phase I), the Biology of Disease in the second year (Phase II), and the Basic Clinical Experience in the third and fourth years. The scheduling of these cores is shown in the accompanying diagram of the organization of the curriculum.

The second curricular concept, the elective program, is complementary to the core curriculum and is an integral part of the overall basic medical education of the student. The student, with the help of an advisor, selects from the electives offered in each of the Phases a program which best provides him the opportunity for in-depth study and career development. Considering the large number of electives available, this program represents in a practical sense the maximum degree of individualization of education.

Medical College of Georgia

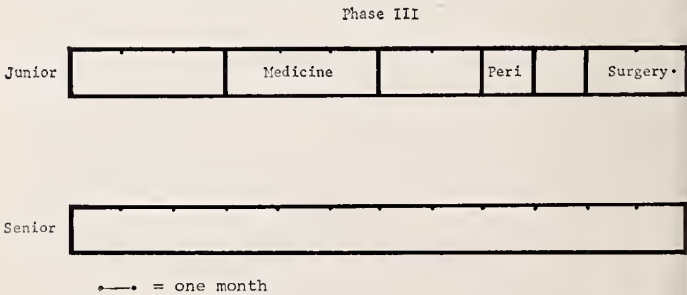
The New Curriculum—Phase III
School of Medicine, Medical College
of Georgia

William A. Scoggin, M.D.
Professor and Chairman

Department of Obstetrics and Gynecology

Phase III of the new curriculum, encompassing the latter two years of medical school, was initiated June 1, 1967.

As mentioned by Dr. Singal in his discussion of Phases I and II, discussions concerning curricular change had occurred over the course of several years and had culminated in a faculty retreat at Highlands, North Carolina in June 1966, at the end of a year of self study co-sponsored by the AAMC. There were a number of factors involved in the decision to change the medical school curriculum, including the information that in line with the experience of other medical schools, the average MCAT score of our entering class was increasing each year, that the members of our entering classes



Tabular representation of Phase III of new curriculum.

TABLE I
PHASE III—1968-69

Department	No. of Students
Anesthesiology	52
Dermatology	69
Endocrinology	32
Medicine	390
Obstetrics and Gynecology	146
Pediatrics	133
Psychiatry	103
Neurology	91
Radiology	104
Surgery	185

included students with a variety of backgrounds, such as engineering, sociology, psychology and even history, as well as those with the standard pre-medical college preparation. In addition, it was observed that young men and women were entering medical school with a variety of life goals, such as the practice of medicine, medical research, biomedical engineering and even academic medicine.

During the year of self study, information obtained from medical students had revealed that the entering classes of highly motivated, interested, eager young people, after being forced through four years of the same mold consisting of a highly structured single track curriculum, had lost some of their initiative, individuality and motivation. While it was thought that the majority of students might select a curriculum similar to that which was formerly required, it was felt that an appropriate reorganization of the curriculum would permit those students who desired to do so to select courses appropriate for their goals and to omit some courses which would be inappropriate.

A faculty curriculum task group worked through the fall and winter of 1966 attempting to design such a flexible curriculum. This was presented to the entire faculty early in 1967 and was accepted in principle. At that time it was decided that it would not be feasible to initiate the desired changes

TABLE II
PHASE III ELECTIVES

Department	1968-69	1969-70
Anatomy	5	4
Biochemistry	3	0
Microbiology	5	7
Pathology	12	11
Pharmacology	6	3
Physiology	4	1
	35	26
Number of students, 1968-69: 14		

in the first and second years immediately, and so the new curriculum was introduced to the Junior class in June 1967.

Requirements for Phase III

The requirements for Phase III include a minimum of 18 and a maximum of 24 months of credit courses, six months of which comprise the core. This core curriculum consists of three months of medicine in general, two months of surgery in general, and one month of perinatology. Figure 1 illustrates one of several possible core assignments. The student must then select, with the help of a faculty advisor, at least 12 months of electives out of the 136 choices available to him. He may elect to take up to six months of vacation.

Results After 21 Months

We have found that the majority of our students have elected more than the minimum requirement; as is indicated in Table I, they have selected a

TABLE III
PHASE III ELECTIVES

Department	1968-69	1969-70
Anesthesia	6	5
Community Medicine	8	8
Dermatology	2	2
Endocrinology	3	2
Medicine	18	22
Obstetrics and Gynecology	14	8
Pediatrics	19	23
Psychiatry	14	13
Neurology	7	10
Radiology	9	4
Surgery	31	33
	131	130
Number of students: 1,307		

rather general curriculum. Table I includes only those clinical electives selected by thirty or more students. Table II lists the number of electives offered by each of our basic science departments during each of the first two years of our new curriculum. It will be noted that only 14 Phase III students have enrolled for basic science electives, considerably fewer than we had hoped. This may be due to the fact that these students had been through the first two years of medical school prior to significant curricular change. Table III indicates the number of electives offered by each of the clinical departments. During the year 1968-69 our 200 Junior and Senior students enrolled for a total of 1,307 electives.

After 21 months, we have observed that the majority of our students do indeed select a course of study similar to that which they would have had

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under the old curriculum, while a few have selected quite unique courses of study. We have noted that considerably more faculty time is involved in the new curriculum than in the old, but that the mere fact of change has infused both faculty and students with a new enthusiasm. Our curriculum is continually reviewed by faculty committees with student representation so that appropriate revisions may be instituted as experience dictates the need.

How Today's Curriculum Committee Plans for Tomorrow's Physician at Emory University

Robert B. Smith, III, M.D.
Assistant Professor of Surgery

In April 1967, Dean Arthur P. Richardson appointed an Ad Hoc Committee to make recommendations to the Advisory Faculty Council of the Emory University School of Medicine concerning possible revisions in the school's curriculum. Prior to the appointment of this Committee, the departmental chairmen had studied the Medical School curriculum and had prepared suggestions for improving the existing curriculum.

The Ad Hoc Committee appointed in 1967 was comprised of Dr. Harry Williams and Dr. Layton McCurdy as co-chairmen, with Dr. William Marine, Dr. Robert Smith, III, and Dr. Ralph Heinz. Dr. Heinz's resignation from the Medical School faculty led to the addition of Dr. Jerry Sutin and Dr. Alexander McPhedran to the Committee. During the following nine months, the Committee met weekly to explore curricula from other medical schools, to discuss the educational process with students from the various classes in our own Medical School, to talk with many departmental chairmen and the Deans of the Emory University School of Medicine, and to study the recommendations of respected national agencies. Dr. Per Stensland of the Milbank Memorial Fund spent two days with the Committee as special consultant. Specific recommendations for curriculum revision were then formulated by the Ad Hoc Committee and presented to the Advisory Faculty Council in January 1968. Several meetings of the Council were devoted to discussion of the proposal, and after careful consideration and a number of modifications, the new curriculum was adopted in principle.

Changes in 1969

The Advisory Faculty Council then decided to implement the third- and fourth-year changes first, beginning with the 1969-70 academic year. Rec-

ommended changes in curriculum to the first two years are still under study by subcommittees, and implementation of that portion of the program will occur when detailed presentations have been approved concerning several new courses requiring interdepartmental, coordinated teaching efforts.

Principles of Revision

The curriculum revision proposed for Emory centers around two principles: (1) additional *flexibility* for diverse medical careers; and (2) methods and environment which will enhance assumption by the student of *more responsibility for his own education*. In the past, a great majority of medical schools required all students to pursue the same four-year program. When this system was developed over 50 years ago it was feasible and appropriate, since medical knowledge at that time was limited, and since nearly all graduates entered a broad form of general practice. Today, however, we are witnessing a significant movement toward specialization in medicine. Even those physicians who elect general practice tend to move toward some area of specialization and will likely have some post-internship training before entering practice. Because of this diversity in medical careers, the university medical school curriculum must possess sufficient flexibility to lend itself to the best education for the job to be done. The introduction of more elective time into the curriculum, coupled with an effective faculty advisory system, should help meet this educational challenge.

Having the student assume greater responsibility for his own education is also of paramount importance. The fact that the students presently in our school will be practicing medicine in the year 2000 indicates the overwhelming importance of continuing education. The seeds of a physician's continuing education must be planted during his medical school years. It is hoped that the structure of the new curriculum will enhance this quality in our students.

Implementation of the New Third and Fourth Year Curriculum at Emory University School of Medicine

Jonas A. Shulman, M.D.
*Assistant Professor of Preventive Medicine and
Community Health, and Coordinator
of Curriculum*

In November, 1968, the third- and fourth-year programs of the revised Emory curriculum were approved by the Faculty Advisory Council for implementation in August, 1969. The junior year of this new curriculum will consist of two-month rotations

in medicine, surgery, pediatrics and psychiatry; a one-month rotation split between anesthesiology and radiology; and one month of gynecology-obstetrics. This is to be followed by only five prescribed months during the senior year consisting of two months of medicine, two months of surgery and one month of gynecology-obstetrics. The remaining 20 weeks of the senior year are to be made up of elective courses to be chosen by the student. These electives will be drawn from clinical clerkships, research opportunities in various departments and basic science courses and seminars. Approximately 150-200 electives will be offered by the faculty during 1969-70. Programs devised by the students to meet his needs will also be considered seriously by the Coordinator of the Curriculum. Furthermore, upon approval of the specific department involved, students may elect work to be taken at other medical facilities.

Two-fold Objective

The major objectives of this portion of the curriculum revision are two-fold. Firstly, a basic rotation through each of the major disciplines is seen as essential in the training of a physician no matter what his future objectives may be. Thus, although a reduction has been made in the amount of prescribed time in each given subspecialty, the student is still required to rotate through all major areas of medicine. This enables him to gain an acquaintance with the many diversified aspects of the profession.

Secondly, the increase in the amount of elective

time to 50 per cent of the senior year has been made to allow flexibility in the student's educational program. Basically, we believe that the elective program will give the students the following opportunities: (1) a greater responsibility for the planning of *his* own curriculum; (2) the planning of a curriculum which he believes is *relevant* to his future goals; (3) the ability to spend more time in areas in which he needs supplemental training; (4) the availability of spending more time in areas of special interest; and (5) the ability to achieve closer faculty contact since many of the elective programs will have student-faculty ratios of 1 to 1.

Individual Planning

This new and flexible curriculum is basically an attempt to allow for an individualization of each student's curriculum. In order to aid the student in the planning of his education, he will first meet with the Coordinator of the Curriculum, who will discuss the general program with the student and aid him in the selection of a faculty advisor. The faculty advisor will work with the student in the final planning of the senior year and hopefully will be able to help him in his decisions concerning future house staff training and career plans.

It is with the spirit of a renewal of close faculty-student contact in the pursuit of an individualized educational program that the students and faculty of Emory University School of Medicine enter into this new curriculum.

EATON OFFERS REVISED CATALOG OF TEACHING FILMS

Now available from Eaton Laboratories, Division of the Norwich Pharmacal Company, is a revised catalog listing 77 titles in Eaton's library of surgical and medical science teaching films. The 16 mm., sound, color films are listed in seven categories: urology, plastic and reconstructive surgery, burn therapy, gynecology, ophthalmology, dentistry, and cardiovascular surgery; and each title is accompanied by an abstract.

A series of six films dealing with uretero-pelvic juncture defect repair has been added recently to the

library. They are: "Classical Foley Y-Plasty in a Horseshoe Kidney," "The Dismembered Foley Y-Plasty," "Modified Davis Intubated Ureterotomy," "Cuff Re-implantation Procedure," "Uretero-Ureteral Anastomosis" and "Vertical Flap Ureteropelvioplasty." It is expected that nearly a dozen more films will be added to the library in 1969.

To schedule showings or get further information, contact your Eaton Representative or write Eaton Medical Film Library, Eaton Laboratories, Norwich, New York 13815.

PLAN TO ATTEND

115th ANNUAL SESSION—MEDICAL ASSOCIATION OF GEORGIA

May 4-7, 1969

Savannah Inn and Country Club—Savannah, Georgia



'There's No Standing Still'

LET IT BE KNOWN in the Annals of the Medical Association of Georgia that the indispensable president (or man) is not numerous. While my term of office has been one of enlightenment and great experience for me, I trust this year has been worthwhile to every member of the Medical Association of Georgia.

There have been recognizable shortcomings on my part, which leaves unlimited horizons for advancement to my successors in the future. Nonetheless, we have had a most successful year. Many advances have been made and the groundwork has been laid for substantial continuation of health care practice under the free enterprise system of medicine, as believed in by the doctors of Georgia. This is not my swan song but a challenge to every doctor to be ever alert against the forces which may destroy our system. Our personal protection will require vigilance and self-sacrifice. It will require understanding, cooperation, and the relinquishing of petty or personal differences. Urge new members to take active parts in organized medicine. We cannot remain status quo, but must roll with the changing times and continue to champion the best interests for the health care of our fellow man.

Our best lessons are learned from our problems, mistakes, and other people. No individual or group, to my knowledge satisfies everyone, but we should continue our trend of progressive thinking. Senator Dirksen said, "life is a matter of development and decay. You either grow or you retrogress. There's no standing still. You go backward or forward. The challenge will make you grow if you are willing to assert a leadership and look to the challenge as something to be met and disposed of." It is not easy to become an adult in a world that even adults don't understand. Reality is not the world we look out on, but the world we look out from.

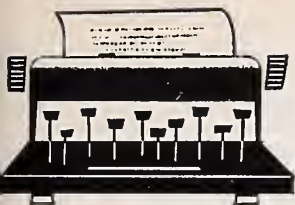
We must not allow our lives to settle into fixed patterns to the extent that we resist or resent any change. It may seem easier to follow customary paths, but we must not turn away from the new, the different, or the untried.

It is with pride that I point to our Medical Association of Georgia, and it is with sincere faith in my colleagues that we will continue to progress and maintain our outstanding role in medical leadership.

In parting, let me again express my appreciation to all for the honor bestowed on me and the wonderful cooperation received during the past year.

Charles R. Andrews Jr. M.D.

Charles R. Andrews, Jr.
President, Medical Association of Georgia



'Town and Gown' Discussions

THE THIRD BIENNIAL CONFERENCE on Medical Education, sponsored by the Medical Association of Georgia, Emory University School of Medicine and the Medical College of Georgia was recently concluded at Callaway Gardens. The conference assembled representatives from both medical schools with practicing physicians from over the State to a two-day discussion of problems confronting the profession. Participants included representatives of basic sciences and clinical faculty, physicians from rural towns and large cities, general practitioners and a variety of specialists, two medical students and a minister. Topics this year included continuing medical education, licensure and re-examination, and training and utilization of allied health personnel. These are problems of mutual interest to educators and practicing physicians, and thus are pertinent topics for "town and gown" discussions.

In addition to the obvious advantage of pleasant fellowship in a delightful surrounding, there are several benefits that accrue as a natural consequence of these meetings. The exchange of ideas on current problems enables opinions to be formed with a broader basis of experience and understanding. It is doubtful if many decisions are made as a direct result of these conferences, but hopefully, the decision makers are influenced by the thoughtful expression of opinions by participants from many varied backgrounds and types of practice. As groups and individuals get to know each other better, there is a natural increase in feelings of trust and understanding, and there emerges a desire to join forces and work together to achieve common goals. This is probably the most important accomplishment of conferences such as this, and it is ample reason for their continuation.

Joseph S. Wilson, M.D.

Asthma in Childhood

THE SYMPTOM COMPLEX of wheezing, coughing, and paroxysmal dyspnea is common in children. The usual episode is mild and self-limited, responding well to antibiotics-bronchodilator-vaporizer therapy. A small number of children have severe and repeated attacks. A significant number have persistent and long-standing airway problems to a handicapping degree. Children in the two latter categories deserve extension of the physician's efforts well beyond simple management of the acute episode.

In infancy, the problem often results from an infectious process compromising already tiny air passages. Occasionally, aspiration of food or other material has occurred. Rarely, a congenital anomaly of the upper airway or bronchial system may be present. Cystic fibrosis is common enough to justify an iontophoretic sweat test on any infant with persistence of these symptoms.

Solid Allergic Basis

In childhood, most asthma has a solid allergic basis, although it may become clinically manifest only during periods of respiratory infection. Seldom is an emotional factor paramount. Some parental anxiety is a natural result of repeated episodes which appear life threatening. Children of school age with marked chronic

airway problems frequently are depressed. Reversal of altered patient or family behavior patterns usually occurs when symptoms are reasonably controlled.

During acute episodes, a chest x-ray may reveal infection or lobar atelectasis, the commonest complications. Usually, the only finding is hyperinflation. Hyperinflation should not be reported as "emphysema," since the latter term is now used widely to denote a specific disorder of older adults. Much undue anxiety has been provoked by this semantic confusion.

The "allergic disposition" of the wheezing child is confirmed by the presence, either historically or on examination, of characteristic allergic reactions of the nasal mucosa, skin, or gastrointestinal tract. Seasonal or environmental changes in symptomatology are frequently noted, as is a significant family history of allergic disorders. A reasonable program of allergic management can usually be instituted by the knowledgeable physician without further investigation.

Allergy Skin Tests

Allergy skin tests are helpful in confirming the presence of an allergic disposition when clinical findings are not clear-cut, and in confirming the general presence of allergic reactivity (pollens, molds, household inhalants, and foods). Parents too often dread such tests for their children; they also want to place too much emphasis upon their literal interpretation. Skin tests are useful chiefly as guides to intelligent planning of "avoidance" programs and for establishing a hyposensitization program, if such appears indicated.

The role of foods as allergic factors in asthma is usually difficult to define. The presence of skin or gastrointestinal problems in infancy hints that foods were and may still be a factor. Skin tests for foods frequently do not correlate well with symptoms. Rarely can a parent incriminate successfully or accurately specific foods without guidance. A food diary may help. Trial with elimination and reintroduction of suspected foods sometimes can implicate a specific food or food group.

Pulmonary Function Studies

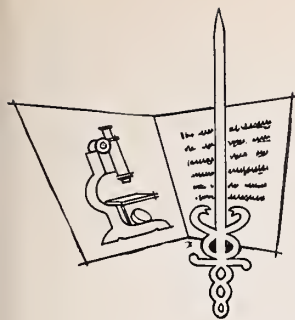
Pulmonary function studies (lung volumes and flow rates) are useful chiefly in subclinical detection of airway flow abnormalities. The physician can often elicit the presence of such abnormalities by careful auscultation over the lower lung fields posteriorly while the child forcefully exhales with his mouth open. Many children thought to be "well" between attacks of asthma will be found to have persistent and sometimes substantial degrees of partial airway obstruction.

Although most children of school age with mild asthma will improve by adolescence, children with severe chronic asthma too often become school dropouts, draft ineligible, vocational drifters, and ultimately recipients of disability assistance in their twenties or thirties.

The physician, in dealing with the allergic child and his parents, must determine early the degree and persistence of the respiratory problem and act accordingly. Most parents need assurance and education. An excellent office aid is a booklet, "Allergy in Children."¹ The more serious the problem, the more attention is warranted to in-depth evaluation and extended medical management; on the other hand, basic knowledge of allergic mechanisms and how to avoid "allergic overload" is desirable for the family of the child with even mild allergic manifestations. Happily, major symptoms can be fairly well controlled in most instances, and the allergic child will usually learn to tolerate with humor and good will the need for reasonable environmental and dietary precautions.

Frank P. Anderson, M.D.

¹ Available in quantity from The Allergy Foundation of America, 501 Second Avenue, New York, New York 10017.



METASTATIC BONE DISEASE

DANIEL B. SULLIVAN, M.D.* *Augusta*

THE DIAGNOSIS OF METASTATIC CARCINOMA to bone brings with it, in many instances, a sense of foreboding to the physician, and certainly a sense of despair for the patient and the patient's family. A frequent corollary of this emotional response is a sense of frustration as far as therapy is concerned, and in other instances, a sense of utter hopelessness in searching for the primary. This attitude, although justified on some occasions, is certainly not justified as a general approach to the problem of metastatic bone disease. It certainly does not alter the pain that the patient has; it does not make the patient more mobile when it may be possible to do so; and certainly it may take away an opportunity to extend a functional life for a year or longer for the patient.

The search for the primary may be rewarding if it happens to be breast in the female, prostate in the male, or a tumor of the lymphoblastic series, occasionally thyroid or kidney.

Basic Tools for Diagnosis

The basic tools that the physician has in making a diagnosis of metastatic bone disease remain the basic tools of making any diagnosis. The history is of utmost importance. The history of the patient in relation to a neoplasm which may be present at the time the patient is seen, or if they have had a neoplasm in the past, will tend to make the diagnosis easier. The history of persistent pain in a given region of the body, associated many times with tenderness over the bony eminence that is involved, is certainly significant.

The history of the neoplasm and its pattern of metastasis is of extreme importance in making a decision about metastatic disease. The x-ray findings with the characteristic changes, either lytic, or blastic, or a mixture of both, are characteristic enough to come to a clinical decision, in a number of instances. The laboratory data with special reference on the serum calcium, alkaline phosphatase, acid phosphatase, uric acid, marrow studies, protein patterns, etc., all will add additional information to the specific nature of the lesions under review.

Physical findings which reveal a primary tumor play a part in a decision as to whether or not the patient has metastatic carcinoma. The biopsy of a given lesion is not always necessary, but in some instances, when in the history of either the patient or the tumor, the physical findings and laboratory data do not correlate, then biopsy is of extreme importance. Isotope data, as far as bone scanning is concerned, will, in the near future, add to our ability to confirm the presence or absence of metastatic disease in the bone, probably before x-ray findings become apparent.

Characteristic Pattern of Pain

The pain that these patients complain about has a fairly characteristic pattern. Review of 102 patients who had proven bone metastasis from the Tumor Clinic at the University Hospital in Augusta and from a private series was evaluated. In

* Member, Professional Education Committee, American Cancer Society, Georgia Division.

102 patients, 98 of these people complained of pain as a first symptom of the development of metastatic bone disease. Pain was absent in four of the 102, two of these were prostatic carcinoma and two of them were breast carcinoma. The pain was present from two weeks to six months prior to the actual demonstration of changes in the bone by x-ray, in many of the instances. This pain was nonresponsive to usual conservative measures for pain relief; that is they were nonresponsive to analgesics, rest, heat, muscle relaxants, or immobilization. In many instances, the pain was associated with point tenderness over the bony eminence involved.

One unusual finding about the pain was that it could be confused with a migratory pain of arthritis. The patients, not infrequently, would complain of stiffness in many parts of the body, pain which was made worse by being still and which improved as they were up and about. This gradually assumed a change in character to become persistent, whether they were active or inactive, but early the pain was migratory in numerous patients.

Three Methods of Treatment

- The treatment of metastatic bone disease consists of three methods of attack:
- (1) Local treatment to the area, and the first choice is radiation therapy.
 - (2) Adjuvant local therapy, internal fixation of long bones in fractures or impending fractures, plus radiation therapy.
 - (3) Systemic therapy which would include hormone additive or ablative treatment in breast and prostate tumor, or chemotherapy in the lymphomas, ovary, for example.

1462 Harper Street

MESSAGE FROM THE PRESIDENT-ELECT

It is time once again to consider appointments to MAG committees. Listed below are all committees of the Medical Association which help carry out MAG policies. Please review the list and at a future date, members will be asked to indicate a preference for committee service. Doctor, we need your time and talent.

John Kirk Train, M.D.,
President-Elect, Medical Association of Georgia

Committees of the MAG

Professional Conduct and Medical Ethics	Allied Health Careers	Occupational Health
Medical Review and Negotiating	Finance	Talmadge Hospital Liaison
Insurance and Economics	Special Finance	Physician-Lawyer Liaison
Public Service	Headquarters Building	GAGP
Rural Health	Woman's Auxiliary	Separate Billing
Medicine and Religion	Cancer	Awards
Disaster Medical Care	Historical	Maternal and Infant Welfare
Mental Health	Constitution and Bylaws	Hospital Activities
Medical Education	Legislation	Blood Banks
Traffic Safety	Board of Medical Examiners Liaison	Nursing Liaison
	School Child Health	Crippled Children



THE RATIONALE FOR TREATMENT OF HYPERTENSION

GLEN E. GARRISON, M.D., *Augusta*

SYSTEMIC ARTERIAL HYPERTENSION is more difficult to delineate from "normal" blood pressure than is often appreciated. Analysis of voluminous data (especially from insurance companies) indicates that the higher the systolic pressure the higher the mortality rate, even when systolic pressures are below the arbitrarily adopted upper limit of normal for systolic pressure (140 mm Hg). Available data also indicate that the higher the diastolic pressure the higher the mortality rate.

The extremely wide variation in the natural history or clinical course of individuals having any of the various levels of blood pressure raises the possibility of increased arterial pressure being produced by multiple different diseases, each having its own prognosis. Certainly multiple specific causes of hypertension have already been discovered; and patients with these conditions should be managed in light of the underlying diseases. However, the vast majority of patients having blood pressure levels customarily designated as hypertension do not have a currently recognizable underlying disease and are, therefore, regarded to have idiopathic or "essential" hypertension.

'Essential' Hypertension

Among patients having "essential" hypertension, those with malignant hypertension (the cardinal feature of which is papilledema) have a uniformly predictable poor prognosis with approximately 80 per cent mortality within one year. The rapid and uniformly poor natural history of this group of patients provides a standard against which the effectiveness of antihypertensive treatment could be compared. The vigorous application of currently available pharmacological agents usually decreases the markedly elevated blood pressure and the abnormal retinal findings (including disappearance of papilledema) if therapy is instituted before renal function is impaired. The survival rate in malignant hypertension can be markedly increased to over 50 per cent at the end of three years by aggressive pharmacological therapy.

Evaluating Therapeutic Program

The effect of treatment in mild and moderately severe hypertension has been difficult to determine because of the long and highly variable natural history. In such situations a *prospective study* following random division of patients into treatment and control groups is the proper way to evaluate a potentially effective therapeutic program or procedure.

In the early 1960's the United States Public Health Service established such a research program in a particular community to evaluate the effectiveness of antihypertensive medication in mild and moderately severe cases. The presence of the project in that town, however, called intense attention to hypertension, and within

several months a large portion of the control group had been placed on therapy by local physicians, making continuation of the study impossible.

VA Cooperative Study Group

Beginning in 1963 the Veterans Administration Cooperative Study Group on Antihypertensive Agents established a cooperative (single protocol) study in 15 Veterans Administration Hospitals to obtain information on this problem. A total of 143 patients having diastolic blood pressures persistently between 90 and 129 mm Hg without therapy were identified. None of these had surgically curable hypertension, uremia, unrelated fatal diseases such as carcinoma, history of intracranial hemorrhage, dissecting aneurysm, or refractory congestive heart failure. Also, none of these patients had exudates, hemorrhages, or papilledema in the optic fundi. These 143 patients were randomly divided into two approximately equal and highly similar groups. The treatment group received a combination of hydrochlorothiazide (usually 50 mg twice a day), reserpine (usually 0.1 mg twice a day), and hydralazine hydrochloride (usually 50 mg three times a day). The control group received placebos which appeared identical to the active medications. The examining physicians did not know whether particular patients were in the treatment or in the control group, making the study *double-blind* in type. In slightly over two years the study was discontinued for those individuals having an initial diastolic pressure between 115 and 129 mm Hg because it had become overwhelmingly obvious that the drugs markedly improved the prognosis of these patients. Four deaths had occurred in the control group, and none had occurred in the treated patients. The occurrence of 27 serious "events" in the placebo group compared to two such "events" in the treated group is even more impressive (difference statistically significant at the $P < .001$ level). Consequently, the combination of antihypertensive agents used was shown to be of great value in this group of patients.

Personal communication with Dr. Edward D. Freis, Chairman of the Study Group, indicates that the possible value of such therapy for patients having initial diastolic blood pressure between 90 and 114 mm Hg is not apparent after an average of four years of follow-up, but this component of the study is still being continued. The report of this cooperative study should be regarded as one of the classical landmarks in cardiovascular research. It was published in the *Journal of the American Medical Association*, volume 202, pages 1028-1034.

Summary

In summary, it can be stated with confidence that pharmacological therapy for hypertension is definitely of value in the "malignant" stage having extremely high blood pressure and papilledema and also in patients having stable diastolic pressures in excess of 115 mm Hg. The potential advantage of therapy for patients with lower levels of blood pressure is quite possible but inconclusive at the present time.

Finally, two points of caution should be made. Each of the various antihypertensive medications has its potential undesirable side effects that fairly frequently require adjustment of dosages or changing to other therapeutic agents. Also, the successful lowering of even markedly elevated blood pressure is at times followed by complications such as the development of transient cerebral ischemic attacks or increasing azotemia which may require discontinuation of therapy. These complications of reduced arterial pressure usually occur only in older patients or in those with far advanced hypertensive vascular disease.



THE MEDICAL PROFESSION AND COLLECTIVE BARGAINING

WILLIAM B. SPANN, JR., *Atlanta**

THE RIGHT TO BARGAIN COLLECTIVELY by employees was first recognized and protected by the law in the National Labor Relations Act, originally passed in 1935 and several times amended. This Act created the National Labor Relations Board for the protection of employees' rights, but the jurisdiction of that Board is based upon interstate commerce and an activity must be found to be "affecting commerce" within the meaning of the Act for the Board to take jurisdiction. Furthermore, the Act, by definition, exempts certain governmental agencies and certain private employers from the Act and likewise exempts certain categories of employees. On the other hand, within the requirements of the statute itself, the policy of the Board has been to expand the coverage of the Act to include additional employers and additional employees. Such an expansion is currently taking place with regard to the practice of medicine and the employees of those who are engaged in medical practice.

The recent controversy between the Georgia Nurses Association and its members who were employed by DeKalb General Hospital on the one hand and the DeKalb Hospital Authority on the other suggests that there should be some clarification concerning the relationship between doctors and employees.

Status of Hospitals

At the outset it should be stated that what is said here has no bearing on the relationship between most hospitals and their employees. The National Labor Relations Act, as amended, excludes from the definition of "employer" "any state or political subdivision thereof, or any corporation or association operating a hospital, if no part of the earnings inures to the benefit of any private shareholder or individual. . . ." Thus, except for proprietary hospitals,¹ all other hospitals, whether publicly operated or privately operated as charitable institutions, are completely exempt from the provisions of the Act.

There is no exemption for the practice of medicine, the practice of dentistry, or any other activity which may be regarded as related to the medical practice. The Board had held in 1960 that it would not take jurisdiction over proprietary hospitals because such hospitals were essentially local operations and did not substantially affect commerce.² This position was reversed in the 1967 holdings taking jurisdiction over proprietary hospitals and nursing homes.

Mayo Clinic Decision

The reasoning of the earlier Board decision about hospitals gave some conso-

* Prepared at the request of The Medical Association of Georgia. Mr. Spann is a member of the firm of Alston, Miller & Gaines, General Counsel to The Medical Association of Georgia.

¹ The Board has set a yardstick of \$250,000 in gross revenue per year for the assertion of jurisdiction over proprietary hospitals. *Butte Medical Properties* (November 16, 1967) 168 NLRB No. 52, 66 LRRM 1259.

On the same day that the Board asserted jurisdiction of proprietary hospitals, the Board established the jurisdictional yardstick of \$100,000 gross revenue per year in establishing jurisdiction over proprietary nursing homes. *University Nursing Home, Inc.* (November 16, 1967) 168 NLRB No. 53, 66 LRRM 1263.

² *Flatbush General Hospital* (Jan. 13, 1960) 126 NLRB No. 22, 45 LRRM 1286.

lation in considering the medical practice, but the changed position of the Board with regard to proprietary hospitals was almost immediately applied to the medical practice. Twelve days after the hospitals and nursing homes decisions, the Board rendered a decision asserting jurisdiction over the Mayo Clinic,³ pointing out that the clinic was not a non-profit hospital, nor was it primarily engaged in education and research, and its operation clearly affected commerce. In this case, Mayo Clinic actually petitioned the Board and asked that it take jurisdiction.

Indeed, a portent of this decision had appeared in 1966 when the Board took jurisdiction over a dental partnership,⁴ but the facts left some doubt of the Board's position regarding medical practice generally since one of the dentists in the partnership owned an interest in some 12 dental partnerships located in California and operated one clinic which he completely owned in Oregon. Although no jurisdictional standards were stated in the *Mayo Clinic* case, the Board in the dental clinic case appears to have applied certain yardsticks.⁵

Jurisdiction of Medical Clinics

In a very recent decision, the Board has affirmed its position in taking jurisdiction of medical clinics⁶ despite the argument that medical clinics are engaged in "humanitarian business" with education and research as an essential element. The Board rested its decision on the fact that the clinic consisted of a partnership of physicians engaged in the practice of medicine for profit.

It may be concluded from the series of Board decisions that the Board recognizes jurisdiction over the practice of medicine and related professions. Once the Board recognizes jurisdiction, it has established certain "yardsticks" to determine the size of the activities over which it will assert jurisdiction, since the Board has taken the position that it is not necessary to effectuate the policies of the Act to assert jurisdiction over activities under a certain size in particular business.

Establishment of 'Yardsticks'

In the two medical clinic cases, the Board has referred to the out-of-state purchases of the clinics and has also referred to the gross revenue of the clinics; however, the Board has not, as it did in the case of proprietary hospitals and nursing homes, referred to the establishment of any definite "yardstick" with regard to medical clinics. It would appear that the out-of-state purchases are set forth in order to establish the jurisdictional requirement of "affecting commerce." If this is the purpose of using the dollar volume of out-of-state purchases, the Board will recognize jurisdiction though this figure is quite low.

Once jurisdiction is established, some yardstick as to volume is usually set up by the Board. In the retail sale of goods or services, the Board yardstick is \$500,000. The two clinics involved in the two cases heretofore decided by the Board have clearly exceeded this figure. The Board has not, however, referred to any figure as a yardstick nor has it referred to the gross revenue from patients as the "sale of medical services." It is believed that eventually, as cases come before the Board in which the gross revenue is much less than in the two clinics considered, the Board will establish as a yardstick a minimum gross revenue below which it will not exercise its jurisdiction, but it is not possible to suggest what this figure will be. If the Board should consider the treatment of patients as the sale of medical services at retail, it may well use the \$500,000 gross revenue figure or it may

³ *Mayo Clinic* 168 NLRB No. 79, 66 LRRM 1334.

⁴ *Dr. J. C. Campbell, Dentist* (1966) 157 NLRB No. 87, 61 LRRM 1464.

⁵ In the *Campbell* case, interstate purchases exceeded \$50,000 annually and retail sales of service exceeded \$500,000 annually.

⁶ *Quain & Ramstad Clinic* (December 6, 1968) 173 NLRB No. 182, 69 LRRM 1558. Out of state purchases were in excess of \$175,000; clinic gross revenue was \$3,176,847.

arrive at a lower figure. It is conceivable that the Board will analogize the medical practice to a non-retail business and thus use the yardstick of \$50,000 of out-of-state purchases, but this seems less likely. In all probability, the Board will establish a separate yardstick for medical practice based upon a gross revenue figure, as it did in the case of proprietary hospitals and nursing homes.

Conclusion

In conclusion, it may be clearly stated that medical practice has no exemption from the jurisdiction of the National Labor Relations Board. On the other hand, the individual practitioner and small partnerships will probably be excluded from Board jurisdiction by the establishment of yardsticks which will determine when the Board will assert its jurisdiction. Whatever may eventually be the activity over which the Board takes jurisdiction, the employees of such activity will be protected in their rights under the act, including the right to bargain.

*Suite 1220
C & S Bank Building*

THIRD DISTRICT AND MUSCOGEE COUNTY SOCIETIES PLAN SYMPOSIUM ON MEDICINE AND SURGERY

The Third District and Muscogee County Medical Societies will present "A Symposium on Medicine and Surgery" Thursday, April 17 at the Ralston Motor Hotel in Columbus. Chairman of the symposium is Robert E. Talley, M.D.

The opening speaker will be Isadore Dyer, M.D., Clinical Professor of Obstetrics and Gynecology at Tulane University School of Medicine. He will present a paper on the "Diagnosis and Management of Vaginal Infections." Following Dr. Dyer will be John W. Braasch, M.D., Surgeon at the Lahey Clinic Foundation, and Assistant in Surgery at Harvard Medical School. Dr. Braasch will deal with the question, "Is Surgery Justified for Diseases of the Thyroid?" The final speaker of the morning session will be Perry S. Macneal, M.D., Associate Professor of Clinical Medicine, University of Pennsylvania School of Medicine in Philadelphia. His subject will be the "Management of the Diabetic Patient Requiring a Surgical Procedure."

Dr. Dyer will open the afternoon session at 2:00 with a paper on "The Gynecological Aspects of the Adolescent and Preadolescent Girl." This will be followed by Dr. Braasch who will discuss "Surgical Jaundice, 1969." The final speaker will be Dr. Macneal with a paper on the "Management of the Patient with Headache." At 4:15, all speakers will participate in a question-and-answer session.

No fee is required for attendance at the scientific sessions, luncheon or reception. The program is acceptable for four elective hours by the American Academy of General Practice.

The Symposium is made possible by a grant from and with the cooperation of Lederle Laboratories.

AAOS SCHEDULES POSTGRADUATE COURSE

The American Academy of Orthopaedic Surgeons will sponsor a postgraduate course on trauma and disease of the upper extremity May 15-17, 1969, in Atlanta, Georgia.

Directing the three-day course of lectures and panel discussions for the Academy's Committee on Injuries will be Dr. Wood W. Lovell, Chief of the Department of Orthopaedic Surgery at Georgia Baptist Hospital and Surgeon-in-Chief of the Scottish Rite Hospital for Crippled Children, Decatur, Georgia.

The course for orthopaedic surgeons, general practitioners, general surgeons, and residents will be held at the Marriott Motor Hotel, Atlanta, in cooperation

with Georgia Baptist Hospital. Each of the three days will be devoted to a single area, opening with the shoulder and upper arm, followed by a day on the elbow and forearm, and the closing day on the hand.

Faculty members include orthopaedists from 11 States and Canada. The program is acceptable for 22 elective hours by the American Academy of General Practice.

For application forms and further information, contact Dr. Wood W. Lovell, 340 Boulevard, N.E., Atlanta, Georgia 30312, or the American Academy of Orthopaedic Surgeons, 430 North Michigan Avenue, Chicago, Illinois 60611.

THE ASSOCIATION



NEW MEMBERS

Abele, Donald C., M.D. Active—Richmond—D	Medical College of Georgia Augusta, Georgia 30902
Allen, Lee T., M.D. DE-2—DeKalb—U	69 Butler Street, S.E. Atlanta, Georgia 30303
Blanchard, Hubert H., M.D. Active—Spalding—P	523 Thomaston Street Barnesville, Georgia 30204
Bruns, William L., Jr., M.D. Active—Richmond—OBG	1167 University Place Augusta, Georgia 30902
Collins, Chappell A., Jr., M.D. Active—Mitchell—GP	25 Perry Street Camilla, Georgia 31730
Collins, Lewis R., M.D. Active—Coweta—I	35 Jefferson Street Newnan, Georgia 30263
Darugar, Bahram B., M.D. Active—Baldwin—SU	Central State Hospital Milledgeville, Georgia 31062
Davis, Alfred L., Jr., M.D. Active—Stephens—PD	800 E. Doyle Street Toccoa, Georgia 30577
Doss, Melvin C., M.D. Active—Stephens—GP	800 E. Doyle Street Toccoa, Georgia 30577
Gates, Edward M., M.D. Active—Floyd—NS	Harbin Clinic Rome, Georgia 30161
Hatipoglu, Vural B., M.D. Active—C-D-H—I	109 Ambulance Drive Carrollton, Georgia 30117
Hayes, Claudette, M.D. Active—C-D-H—GP	Ambulance Drive Carrollton, Georgia 30117
Jarrett, Eugene C., Jr., M.D. Active—Richmond—PD	Gracewood State Hospital Gracewood, Georgia 30812
Jernigan, William C. T., M.D. Active—Muscogee—GP	2121 Warm Springs Road Columbus, Georgia 31904
Johnson, Margaret W., M.D. Active—Coweta—Path	Coweta General Hospital Newnan, Georgia 30263
Johnson, Marvin E., M.D. Active—C-D-H—Path	Tanner Memorial Hospital Carrollton, Georgia 30117
Kanavage, Chester B., M.D. Active—Altamaha—SU	413 N. Main Street Baxley, Georgia 31513
Lawrence, John C., M.D. Active—Stephens—PD	800 E. Doyle Street Toccoa, Georgia 30577
Lovvorn, John R., M.D. Active—Floyd—P	Harbin Clinic Rome, Georgia 30161
Mendez, Salvador A., M.D. Active—Baldwin—P	Central State Hospital Milledgeville, Georgia 31062

Mitchell, John C., M.D. Active—Richmond—OBG	1167 University Place Augusta, Georgia 30902
Neisuler, Ross F., M.D. Active—Muscogee—I	P. O. Box 2299 Columbus, Georgia 31902
O'Connell, Michael J., M.D. Active—Ware—OR	1921 Alice Street Waycross, Georgia 31501
O'Dell, Edward T., M.D. Active—Floyd—I	Batley State Hospital Rome, Georgia 30161
O'Quin, William P., M.D. Active—DeKalb—GP	123 E. Ponce de Leon Decatur, Georgia 30030
Parrish, Joe E., M.D. Active—C-D-H—OBG	115 Hospital Drive Carrollton, Georgia 30117
Pomeroy, William L., Jr., M.D. Active—Ware—I	1921 Alice Street Waycross, Georgia 31501
Proctor, Robert F., M.D. Active—Spalding—I	231 Graefe Street Griffin, Georgia 30223
Reid, Raymond J., Jr., M.D. Active—C-D-H—GP	P. O. Box 325 Tallapoosa, Georgia 30176
Scott, Harry W., M.D. Active—Floyd—D	Harbin Clinic Rome, Georgia 30161
Singletary, Elizabeth A., M.D. Active—Richmond—I	Medical College of Georgia Augusta, Georgia 30902
Strong, James S., Jr., M.D. Active—Richmond—R	Medical College of Georgia Augusta, Georgia 30902
Wilson, Louis A., M.D. Active—Richmond—OPH	905 15th Street Augusta, Georgia 30901
Wray, Betty B., M.D. Active—Richmond—PD	Medical College of Georgia Augusta, Georgia 30902

SOCIETIES

Neurologist G. G. B. Bilsten, M.D. of Atlanta was the guest speaker at the February meeting of the **Dougherty County Medical Society**.

The featured speaker at the March meeting of the **Georgia Medical Society** was Dr. Quenton Hand, Professor of Pastoral Care, Candler School of Theology and Emory University. His subject was "Pastoral Counseling Service." At the February meeting of the Society, Dr. Robert H. Howard, former chairman of the GMS Blood Bank Committee conducted a program on the "Practical Aspects of Blood Banking."

Members of the **Carroll-Douglas-Haralson Medical Society** heard an interesting talk on thrombophlebitis presented by Dr. Garland Perdue at the February meeting of the Society.

Dr. Robert Vaughn of Columbus was guest speaker at the January meeting of the **Randolph-Stewart-Terrell County Medical Society**. The subject of his presentation was "Hiatal Hernia."

James L. Goddard, M.D., Vice President, Health Sciences, EDP Technology, Inc. was the program speaker at the March meeting of the **Fulton County Medical Society**. His title was "Drugs, Doctors and Patients."

PERSONALS

First District

M. M. Schneider of Savannah discussed "Sex Education for Youth" at a recent meeting of the Southside Optimists Club.

The new general chairman of the 1969 United Jewish Appeal and Federation campaign is **Bernard Portman**.

Third District

Robert C. Garrett of Macon has located in Vienna and is associated with **J. T. Christmas** in his offices.

At the January meeting of the Randolph-Stewart-Terrell County Medical Society, the members elected **John Bates** and **Carl Sills** as delegate and alternate delegate respectively to the MAG.

Fourth District

Decatur neurosurgeon **Ellis B. Keener** spoke before a meeting sponsored by the Greater Atlanta Chapter of the Epilepsy Foundation of America on February 26. The purpose of the meeting, which was open to the public, was to eliminate the misunderstanding about epilepsy which affects more than 16,000 people in the metropolitan Atlanta area.

Physicians in Griffin have voted to name the intensive coronary care unit to be constructed at the Griffin-Spalding Hospital in honor of the late **Harry King** who died in December 1968.

Fifth District

J. Frank Walker has been elected president of the American College of Radiology at the annual meeting of the College held in Atlanta in February. Dr. Walker is a fellow of the American College of Radiology, and served last year as chairman of the Board of Chancellors for the College. He is a past president of the Georgia Radiological Society, the Atlanta Clinical Society and the Emory University Alumni Association. He is a delegate from Georgia to the American Medical Association, and serves on the council on legislation. He is also president of the Atlanta T.B. Association, on advisory councils for Emory School of Medicine and the Southern School of Pharmacy, and president of the Fulton County Medical Society.

F. William Dowda has been asked to serve as Chairman of the National Committee on Comprehensive Health Care Planning for the American Society of Internal Medicine.

Thomas L. Tidmore, Jr. delivered a paper on "Respiratory Therapy in Newborns" to a group at the Chicago Children's Hospital.

The Kiwanis Club of Druid Hills installed **William A. Hopkins** as president for 1969.

The honorary degree of Bachelor of Laws was conferred on **Arthur Pruce** by the Massey Law School. Dr. Pruce had served as lecturer on Medicine and Law during the 1967-68 school year.

Bruce Logue recently attended the meeting of the American College of Cardiology in New York City where he moderated a panel on "Early Manifestations of Heart Failure." He was also a participant on the Master Teachers Program.

The American College of Radiology conferred the degree of Fellow upon **Albert A. Rayle, Jr.** of Atlanta at the recent meeting of the College.

William L. McDougall, Jr. is the new president of the Emory Medical Alumni Association. Other officers elected at the meeting are vice president **Luther G. Fortson, Jr.**, of Marietta, and secretary-treasurer **Wytech Stubbs, Jr.**, of Decatur. **William G. Whitaker, Jr.** of Atlanta and **M. C. Adair** of Washington were elected to three-year terms as trustees. The officers will assume their new positions July 1.

Grady S. Clinkscales, Jr., **E. Ladd Jones, Jr.**, and **Edward C. Loughlin, Jr.** have been inducted as Fellows of the American Academy of Orthopaedic Surgeons.

Atlanta dermatologist **Robert P. Shinall** received the 1968 Aven Citizenship Award given by the Fulton County Medical Society. The Aven Cup is presented annually to an Atlanta physician who has made "outstanding contributions in the fields of welfare, education, health, governmental boards, or the arts."

Sixth District

William Birdsong has been elected president of the Parkview Hospital staff in Macon. The new vice president is **Sam Patton**.

Seventh District

A. I. Miller, a Smyrna psychiatrist, spoke before the January meeting of the Woman's Auxiliary to the DeKalb County Medical Society. His subject was "The Pressures of Medical Practice on the Physician and His Family."

Tenth District

Corbett Thigpen of Augusta was selected by the Freedoms Foundation at Valley Forge to receive the George Washington Honor Medal Award for Public Address for his paper, "A Psychiatrist Looks at His Nation."

Mark Brown of Augusta was made a Fellow of the American College of Radiology at the meeting held in Atlanta in February.

Hartwell physician **Terrell B. Tanner** addressed the dinner meeting of the Northeast Georgia Chapter of the Georgia Heart Association in January.

Washington Physician **Edward Pollock** was guest speaker at a meeting of the Christian Fellowship Workers of the Crawfordville Baptist Church. His topic was the "Emotional Problems of Teenagers."

Donald L. Branyon, Jr., and **William J. Hardman, Jr.**, both of Athens, will be installed as Fellows of the American College of Obstetricians and Gynecologists at its annual Meeting April 28-May 1 in Bal Harbour, Fla.

DEATHS

Robert Marvin Avery

Robert Marvin Avery, LaGrange physician died at his home February 8.

A native of Chambers, Alabama, Dr. Avery received his degree from the Medical School of the University of Alabama, and served his internship in Birmingham. In 1916 he began general practice in the Whitesville Community of Harris County, and later moved to the Union Community of Harris County. In the 1920's, Dr. Avery did specialty work in eye, ear, nose and throat in New Orleans, and in 1938, he moved to LaGrange.

Dr. Avery was a member of the Troup County Medical Society, and a 50-Year Honorary Member of the Medical Association of Georgia.

He is survived by his wife; two daughters, Mrs. Frank Hutchinson, Jr., of Athens, Ala., and Mrs. Arthur E. Mallory, Jr., of LaGrange; two sons, Dr. William G. Avery of Atlanta, and R. Marvin Avery of Huntsville, Ala.; three brothers, Curtis B. Avery, Sr., of West Point, Herbert L. Avery of Jacksonville, Fla., and G. B. Avery of Gabbettville.

Warren Franklin Brown

Warren Franklin Brown, Atlanta plastic surgeon, died February 19 at the age of 37.

A native of Dayton, Tennessee, Dr. Brown received his M.D. degree at 23 and served his internship at Grady Hospital. He then spent a year in private practice at Roswell and completed his general surgeon residency at Georgia Baptist Hospital. After his residency, he received a fellowship and studied at the Mayo Clinic in Rochester, Minnesota.

Dr. Brown is survived by his wife and two children.

L. S. Boyette

General practitioner L. S. Boyette died January 29 at his home in Ellaville.

A native of Draneville Community in Marion County, Dr. Boyette attended Mercer University and graduated from the University of Georgia School of Medicine. He interned at Spartanburg, S.C. General Hospital and the Wilhenford Women's and Children's Hospital in Augusta. In 1935 he began his practice in Ellaville.

Dr. Boyette was president of the Bank of Ellaville, a position he held at the time of his death, and a former member of the Schley County Board of Commissioners. He was a past president of the Sumter County Medical Society, and in January was elected to serve again. He was also a member of the Southern Railroad Medical Association, the Schley County Board of Health, the Southern Medical Association, the American Medical Association, the American Academy of General Practice and the Medical Association of Georgia.

Survivors include his wife; two sisters, Mrs. H. W.

Sappington of Buena Vista and Miss Alma Boyette of Atlanta.

Eleanor Bundy

Decatur physician Eleanor Bundy died February 17 in a private hospital at the age of 51.

A native of Manila, Dr. Bundy had practiced in Decatur since 1953. She was graduated from the Women's College of North Carolina and the Medical College of Virginia. She was a member of the DeKalb County Medical Society, the Medical Association of Georgia, the American Academy of General Practice and the American Medical Association.

Dr. Bundy is survived by her mother, Mrs. E. B. Bundy; a sister, Miss Wilhelmina E. Bundy and a brother, Herbert N. Bundy, all of Decatur.

Harry Hutchins, Sr.

Buford general practitioner and surgeon, Harry Hutchins, Sr., died February 1 at his home.

A native of Buford, Dr. Hutchins was a graduate of Emory University and the University of Maryland Medical School. He opened his practice in Buford in the early 1940's.

Survivors include his wife; five daughters, Mrs. Harold Kemp, and Vivian, Marjorie, Emily and Elizabeth Hutchins; a son, Harry Hutchins, Jr., all of Buford; two brothers, Dorsey Hutchins of Winder, and John Hutchins of Buford; and two grandchildren.

Lindsey Franklin Lovett

Lindsey Franklin Lovett, 46, died February 16 in an automobile accident.

A native of Leesburg, Florida, Dr. Lovett had lived in Statesboro for the past 11 years. He was a graduate of the Emory University School of Medicine, and was associated with the Memorial Clinic in Statesboro. Dr. Lovett was a member of the Ogeechee River Medical Society, the Medical Association of Georgia, and the American Medical Association.

Survivors include his wife; three daughters, Mrs. William A. Veech, of Princeton, N.J., Miss Cathy Lovett and Miss Karen Lovett of Statesboro, and a sister, Mrs. Walter C. Holland, Jr., of Brevard, N.C.

William Francis Tanner

William Francis Tanner, retired physician, died February 2 in a Chattanooga, Tenn. hospital.

A native of Hall County, Dr. Tanner was with the U.S. Department of Health before opening his private practice in Young Harris. He was also the college physician at Young Harris Junior College. After retiring from practice last July, Dr. Tanner moved to Chattanooga to live with his daughter, Miss Jane Tanner.

Other survivors include his son, William F. Tanner, Jr., of Tallahassee, Fla.; a brother, H. H. Tanner, of Palatka; three grandchildren, William F. Tanner, III, Bruce Rigby Tanner and Julianne Tanner, all of Tallahassee.

HIGHLIGHTS OF EXECUTIVE COMMITTEE OF COUNCIL MEETING, FEBRUARY 23, 1969-ATLANTA

This summary is being published so that the MAG membership may be advised in brief of the actions of the Association's Council and Executive Committee. It covers only major actions and is not intended as a detailed report. Full minutes of these meetings are available upon any member's request to the MAG Headquarters Office.

Heard a report by GRM Program Director, Dr. J. Gordon Barrow, on the grant application now being submitted, and also learned that the Georgia program had been rated as one of the top ten RMP's in the country.

Voted commendation of Dr. Barrow for his work with GRMP.

Directed that the nomination of Dr. J. W. Chambers be submitted to AMA for consideration for appointment to a new Committee on RM Programs.

Reviewed a proposed draft of a Bill to create a composite Board of Medical Examiners, along with reports from Councilors regarding their Districts' opinions and voted seven to one to approve the preparation of the Bill into final form and instruct the Legislative Committee to support its passage in the current legislature.

Received a report from Fourth District Councilor,

Dr. Floyd Sanders, on a possible breakdown of communications in releasing an MAG policy statement dealing with Hospital-Nurse Relationships.

Heard a review of current State legislation having medical implications.

Voted to oppose HB 255, the Voluntary Sterilization Bill, in its present form and to draft a substitute; and to oppose HB 437, which would extend the Institutional license privilege to hospital authorities.

Appointed a Committee on Areawide Health Planning and named the following members: William F. Dowda, M.D., Chairman; Henry Jennings, M.D.; Louis Hazouri, M.D.; Lee Battle, M.D.; Waddell Barnes, M.D.; Preston D. Ellington, M.D.; T. A. McGoldrick, M.D., and Neal Yeomans, M.D.

Appointed Dr. Brooke F. Summerour, of Dalton to the Hospital Activities Committee.

Assigned responsibility for matters of fees under Workmen's Compensation Insurance to the Committee on Medical Review and Negotiating.

Directed the President to appoint a three-man committee to investigate a dispute regarding a hospital Medicaid claim and Travelers Insurance Company.

Approved a Georgia Baptist Hospital Staff agreement creating a fund to receive Third Party Payments on non-private patients.



for psychiatric treatment

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□ Treatment procedures include psychotherapy, electroconvulsive shock therapy, subinsulin coma and chemotherapy □ We will be pleased to provide further information upon request.

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THE MONTH IN WASHINGTON

The American Medical Association told Congress that the Internal Revenue Service acted arbitrarily and completely ignored the facts in imposing a tax on revenue from drug advertising in journals of tax-exempt medical associations.

Bernard D. Hirsh, AMA general counsel, testified before the House Ways and Means Committee, that the relation between the tax-exempt purposes of a medical association, national or State, and the drug advertising in its journal is self-evident.

Drug Advertising in Journals

"Drug advertising alerts and stimulates the physician's interest in new drugs as they become available, and also serves to remind him of the broad spectrum of useful time-proven drugs," Hirsh said. "Obviously physicians should not and do not rely upon drug advertisements as their principal source of information, but drug advertisements often provide an important step in the process through which physicians become educated in the therapeutic value and risks of new drugs and a wider variety of useful drugs. . . .

"No other advertising provides as much complete and objective information."

Hirsh said the IRS regulations taxing medical associations on their advertising revenues represents an attempt to change the law without congressional action. The IRS officials made a mistake, he said. "We urge that this mistake be rectified expeditiously and in the most practical way possible," Hirsh said.

Spokesmen for numerous other tax-exempt associations joined the AMA in opposing the tax on their advertising revenues. These included the American College of Physicians, the American College of Obstetricians and Gynecologists, the American Psychiatric Association, the American Dental Association, the Boy Scouts of America, the Girl Scouts of America, the American Chemical Society and the Society of National Association Publications.

"Unfair Advantage"

Representatives of commercial publishing firms contended in testimony before the committee that the previous tax exemption gave the journals of the associations an unfair advantage in competition for advertising dollars. When the IRS announced the new tax regulations 15 months ago, it stated that the purpose of the regulations was not to raise Federal revenue but to remove a competitive advantage of the tax-exempt associations.

In an announcement not directly connected with the House committee hearings, the IRS said it also is considered taxing the income tax-exempt associations get from rental of exhibit and display space at conventions.

Combatting Alcoholism

A special advisory committee urged an extensive national program to combat alcoholism. The National Advisory Committee on Alcoholism said in an interim



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Leonard T. Maholick, M. D.
Medical Director

Maj. Gen.(Ret.) Howard Snyder
Administrator

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report that attention should be given to alcoholism problems in all Federally supported health and welfare programs. The committee also recommended: Elimination by hospitals of discriminatory policies denying admission to alcoholic patients; health insurance coverage for alcoholics; increased support for research; prevention and control of alcoholism as a vital part of national highway safety programs.

National Advisory Committee

The advisory committee provides advice and guidance to the Secretary of Health, Education and Welfare concerning the department's activities related to alcoholism. Robert Straus, Ph.D., professor of medical sociology at the University of Kentucky Medical School, is chairman of the committee. It was created in October, 1966. Its members represent all sections of the country and include experts from the fields of medicine, psychiatry, sociology, vocational rehabilitation, law, and public health.

"The magnitude of the problem is enormous," Dr. Straus said. "Our country has more than 5,000,000 alcoholics. Their suffering alone is intolerable, but the need for increased action is made even more imperative by the fact that affected families may include as many as 20 million Americans."

He also pointed out that alcoholism has a tremendous impact on business, causing absenteeism and loss of productivity.

Alcoholism Research Program

The National Institute of Mental Health awarded a first-year grant of \$250,000 for a major alcoholism research program at the State University of New York, Downstate Medical Center, New York, N.Y.

The five-year program will include experimental and clinical studies, training, and drug trials. In one study, 60 newly admitted patients between the ages of 25 and 55 with at least a five-year history of alcoholism will be studied to determine the effects of experimentally induced intoxication and withdrawal on the subjects' sleep patterns, behavior and biochemistry. The investigators will focus upon the mechanisms underlying the development of physical and psychological dependence.

Among the drugs to be tested are haloperidol, dexoadrol, disulfiram (antabuse), paraldehyde and chlordiazepoxide alone and in combination with a tranquilizer and an antidepressant.

Inoculating Against Rubella

The Federal government is planning to launch a five-year, nationwide program of inoculation against rubella, or German measles, as soon as a vaccine is licensed and available in sufficient quantities. It is expected a vaccine will be available by next fall.

Two drug manufacturers had announced before March 1 the development of a vaccine. Two others were developing one. Merck & Co., Rahway, N.J., was the first to announce completion of testing of such a vaccine. The Merck vaccine, which is of the HPV-77 strain, was reported 95 per cent effective in vaccination of 18,000 children and adults. Merck also has been testing a one-shot vaccine against German measles, common measles and mumps.

Modified Live Virus Vaccine

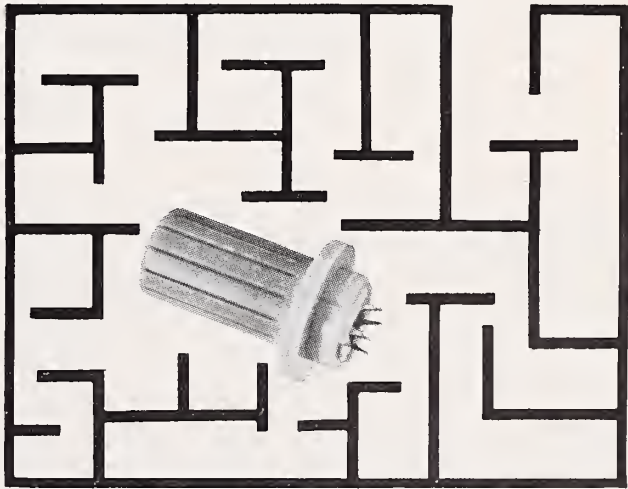
PEPI Inc., New York, N.Y., said that it had developed a modified live virus vaccine, also of the HPV-77 strain, for the disease and that, after being licensed, it would be marketed by Philips Roxane Laboratories and Parke Davis & Co. PEPI said initial production would be primarily a single-dose vaccine for use in pediatric practice, but that later production would include dosage forms suitable for government-sponsored mass-vaccination programs.

The other two companies developing a rubella vaccine are Smith, Kline & French Laboratories, Philadelphia, and Eli Lilly & Co., Indianapolis. Eli Lilly has been developing a HPV-77 strain. Smith, Kline & French was working on a Cendehill strain. It had proved 95 per cent effective in inoculations of more than 25,000 persons, according to the manufacturer. Another vaccine, using a rubella strain RZ 27-3, has been developed at the University of Pennsylvania.

Professional Corporations

Representative Ancher Nelsen (R., Minn.) has introduced legislation calling for the same Federal tax treatment for professional corporations of physicians organized under State laws for business corporations. "We are overdue in acting to guarantee this same right of organization to professional persons that we have always given other forms and types of businesses," Nelsen told the House.

He noted that the Federal government's so-called Kintner regulations issued in 1960 primarily keyed taxation of professional corporations to State law. "As a result," he said, "many States, Minnesota included,




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WASHINGTON / Continued

passed laws enabling incorporation under these regulations. Assuming the air was cleared, many corporations were formed. However, in 1965, the Internal Revenue Service issued new regulations reversing its position, which if upheld, make it almost impossible to create a professional corporation, regardless and in spite of State laws permitting the same.

"No business can operate without some basis of continuity of the ground rules. If any set of rules should be stable, the rules governing the basic tax classification of businesses for tax purposes should be stable and not subject to administrative whim. Businesses, almost without exception—except for the professions with which this bill deals—are now allowed to decide whether to adopt the partnership, association or corporate form under applicable State laws. There is no logical reason for denying this choice to persons who are rendering personal services in the medical or legal fields. Fairness and equity in application of the Federal income tax laws demands that all businesses be treated alike in this sense.

Minimal Loss of Revenue

"The only apparent reason for the 1965 amendments to the regulations was to prevent a possible reduction in Federal revenues. I am certainly convinced that this is not an adequate reason for ignoring years of legal precedent and congressional intent in this field. Furthermore, the providing of health, pension and profit-sharing plans through tax incentives under the

corporate structure is a worthy objective and a legitimate use of the tax laws. Indeed, I am advised that any possible total tax revenue loss will be minimal when it is realized that most profits will be ultimately taxable, even though such taxation might be immediately deferred.

IRS Position Is Unfair

"The position taken by the Internal Revenue Service in 1965 is untenable. It violates fairness, equity, reasonableness, years of legal precedent, and the intent of Congress as to the tax treatment of business organizations operating legitimately under State law. I would urge all my colleagues to support hearings and passage of this needed legislation at the earliest possible date."

Title XIX and Blue Cross

Senator Clinton Anderson (D., N.M.) introduced a bill to tie medicare and medicaid payments to hospitals and nursing homes to local Blue Cross allowances. The bill complements a measure introduced by Senator George D. Aiken (R., Vt.) earlier this year which ties physicians' charges to Blue Shield schedules. Aiken co-sponsored Anderson's bill. Co-sponsoring both bills are Senator Mike Mansfield (D., Mont.) and Senator Winston L. Prouty (R., Vt.). Anderson co-sponsored Aiken's bill.

Anderson also said he supports the idea of Senator John J. Williams (R., Del.) that Congress should give medicare and medicaid programs a close look, perhaps a full-dress investigation.

HIGHLIGHTS OF COUNCIL MEETING MARCH 8, 1969

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Heard a report from MAG Auditor, Mr. Wayne Drake, of Ernst and Ernst, and voted a transfer \$10,000 from operating capital to the 1969 Contingent budget.

On recommendation of the Executive Committee and the Chairman of the Committee on Finance, approved an additional payment to the Employee Retirement Fund of \$123.90 as a first step toward providing a \$25,000 minimum at retirement for two long-term employees.

Approved reimbursing up to \$150 each the representatives of Georgia's two SAMA Chapters for their travel to the MAG annual meeting.

Approved reimbursing the expenses of Dr. Alex Jones up to \$250 to attend an AMA Conference on proposed new standards for hospital accreditation.

Approved a list of additions to the building contract totaling \$56,633.

Approved an Executive Committee recommendation that MAG adopt a fiscal year of June 1-May 31 and requested the Constitution and Bylaws Committee to draft a proposed amendment to accomplish that change.

By a vote of 15 to 6 affirmed the action of the Executive Committee supporting legislation introduced by the Board of Medical Examiners creating a Composite Board to license M.D.'s and D.O.'s.

Approved for forwarding to the House of Delegates without recommendation all amendments proposed by the Committee on Constitution and Bylaws.

Voted to adopt a position opposing legislation which would require that payment for psychiatric services be included in all insurance contracts written in Georgia.

Received for information a report that the AMA Convention Services Bureau now questioned the ability of Atlanta to host the 1972 AMA Clinical meeting. The Atlanta Convention Bureau will host a meeting of the Atlanta Board of Aldermen April 3 in an effort to obtain a date for the completion of the proposed Civic Center Coliseum and divert a possible re-location of the 1972 Clinical meeting by the AMA at its July '69 meeting.

HIGHLIGHTS OF EXECUTIVE COMMITTEE OF COUNCIL MEETING, MARCH 8, 1969

This summary is being published so that the MAG membership may be advised in brief of the actions of the Association's Council and Executive Committee. It covers only major actions and is not intended as a detailed report. Full minutes of these meetings are available upon any member's request to the MAG Headquarters Office.

Heard a report from the Chairman of the Committee on Finance that additional payments to the MAG Employee Retirement Fund in the amount of \$6,460.94 and \$1,662.96 for three years and 10 years respectively would provide the desired \$25,000 minimum at retirement for two long term employees.

Voted to recommend to Council that they appropriate the necessary \$123.90 addition to the already budgeted \$8,000 contribution to the retirement fund to provide the above mentioned minimums.

Received by introduction Mr. Carl G. Bailey, MAG's new Field Representative.

Decided to recommend to the State Board of Health that in light of present situations they consider some

liberalization of cost policy where such procedures as Kidney Dialysis for Medicaid patients exceed the range of the usual and customary fee concept.

Determined that a subcommittee of the Hospital Activities Committee be the permanent committee to receive any future requests for review of unusual hospital claims under Title XIX.

Received for information a report that the AMA Convention Services Bureau now questioned the ability of Atlanta to host the 1972 AMA Clinical meeting. The Atlanta Convention Bureau will host a meeting of the Atlanta Board of Alderman April 3 in an effort to obtain a date for the completion of the proposed Civic Center Coliseum and divert a possible re-location of the 1972 Clinical meeting by the AMA at its July '69 meeting.

Referred the matter of extra charges by hospital based physicians to CHAMPUS for procedures done after 5:00 p.m. or on week ends, and the classification of all deliveries as emergencies requiring an extra fee, to the Committee on Medical Review and Negotiating for report back.

COBB COUNTY SYMPOSIUM HELD MARCH 6-7

The fourth annual Cobb County Symposium, co-sponsored by the Cobb County Medical Society through its Committee on Medicine and Religion, the Marietta-Smyrna Ministerial Association, the Cobb Judicial Circuit Bar Association, and Kennesaw Junior College, was held March 6-7 on the campus of Kennesaw Junior College in Marietta. The theme of the Symposium was "The Progress of Man Toward the Year 2000" and featured the following speakers: Dr. William G. Pollard, Executive Director of the Associated Universities of Oak Ridge, Tennessee, a world renowned nuclear physicist and Episcopal priest; Dr. Joseph Fletcher, Professor of Social Ethics of the Episcopal Theological School, author of *Morals in Medicine*, etc.; Dr. David M. Hume, Professor and Chairman, Department of Surgery, Medical College of Virginia, Richmond, Virginia, and pioneer in renal transplantation; Judge Griffin B. Bell, of the United States Circuit Court of Appeals; Dr. Robert P. Nenno, Professor of Psychiatry, Rutgers University School of Medicine; and Dr. Max Lerner, syndicated columnist and Professor of American Civilization and World Politics at Brandeis University. Subjects covered were "The Meaning of the Twentieth Century Revolution," "Perspectives in Areas of Psychiatry and Mental Health," "Theological Aspects Related to Law and Medicine," and "Perspectives in Areas of Medical Advances."

The Symposium was attended by over 1,300 persons, including many physicians from the entire State of Georgia, clergymen, lawyers, educators, and students from professional schools. Attending as a representative from the Department of Medicine and Re-

ligion, American Medical Association, Chicago, was Mr. Carl Peterson.

The theme for Symposium '70 is "Frontiers of the Mind," and anyone wishing to be placed on the mailing list for this program should write Dr. Luther G. Fortson, Kennestone Hospital, Marietta, or the Department of Continuing Education, Kennesaw Junior College, Marietta, 30060.



Howard M. Sigal, M.D. (left) and Noah D. Meadows, M.D. (right) discuss the program with Max Lerner, one of the guest speakers at the Cobb County Symposium.

CALENDAR OF MEETINGS

In Georgia

- April 17—"A Symposium on Medicine and Surgery, Ralston Motor Hotel, Columbus.
- May 4-7—115th MAG Annual Session, Savannah Inn and Country Club, Savannah.
- May 18-21—Annual Meeting of the Georgia Public Health Association, DeSoto Hilton Hotel, Savannah.
- June 27-July 3—Annual Meeting of the American Society of Radiologic Technologists, Regency-Hyatt House, Atlanta.

In the Nation

- April 17-19—Orthopaedic Symposium, "Problems of the Knee—Traumatic and Reconstructive," Warwick Hotel, Houston, Tex.
- April 17-22—American Dermatological Association, Marriott's Camelback Inn, Scottsdale, Ariz.
- April 18-19—Seminar on Arthritis and Collagen Diseases, Mayflower Hotel, Jacksonville, Fla.
- April 18-20—American Society of Internal Medicine, Palmer House, Chicago, Ill.
- April 20-25—American College of Physicians, Conrad Hilton, Chicago, Ill.
- April 21-23—American Academy of Pediatrics, Boston, Mass.
- April 21-24—Industrial Medical Association, Shamrock Hilton, Houston, Tex.

- April 21-26—American Academy of Neurology, Washington Hilton, Washington, D.C.
- April 27-May 1—Southeastern Surgical Congress, Roosevelt Hotel, New Orleans, La.
- April 28—National Cystic Fibrosis Research Foundation, Marlborough-Blenheim Hotel, Atlantic City, N.J.
- April 28-May 1—American College of Obstetricians and Gynecologists, The Americana, Bal Harbour, Fla.
- April 28-30—American Radium Society, Bellevue Stratford, Philadelphia, Pa.
- April 28-May 1—Southeastern Surgical Congress, Roosevelt Hotel, New Orleans, La.
- April 29—American Society of Therapeutic Radiologists, Bellevue Stratford, Philadelphia, Pa.
- April 29-May 3—Student American Medical Association, LaSalle Hotel, Chicago, Ill.
- April 30-May 1—American Pediatric Society, Traymore Hotel, Atlantic City, N.J.
- April 30-May 2—American Surgical Association, Netherland-Hilton, Cincinnati, Ohio
- April 30-May 3—Neurosurgical Society of America, Key Biscayne Hotel, Key Biscayne, Fla.
- April 30-May 3—American Association of Plastic Surgeons, Fairmount Hotel, San Francisco, Calif.
- May 2-4—American Academy of Psychoanalysis, Holiday Inn, Bal Harbour, Fla.
- May 2-5—American Psychoanalytic Association, Deauville Hotel, Bal Harbour, Fla.
- May 3—American College of Psychiatrists, Bal Harbour, Fla.
- May 4-5—American Society for Clinical Investigation, Chalfonte-Haddon Hall, Atlantic City, N.J.
- May 5-7—American Gynecological Society, Royal Orleans Hotel, New Orleans, La.
- May 5-9—American Psychiatric Association, Americana Hotel, Bal Harbour, Fla.
- May 6-7—Association of American Physicians, Haddon Hall, Atlantic City, N.J.
- May 8-10—National Conference on Breast Cancer, Shoreham Hotel, Washington, D.C.
- May 8-10—American Association for the History of Medicine, Baltimore, Md.

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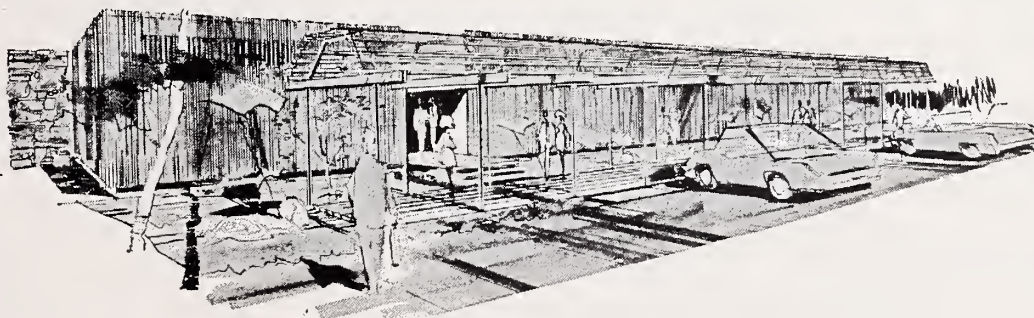
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**The Yerkes Regional Primate
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This unusual research facility within our State is making significant contributions to our basic knowledge of health and medicine.

Special Article

The Yerkes Regional Primate Research Center of Emory University

GEOFFREY H. BOURNE, D.Phil., D.Sc., F.Z.S., *Director*

THE YERKES PRIMATE CENTER is the world's oldest continuously operated center for primate research. The conception of the use of apes as experimental animals in order to solve some of the elementary problems in psychology originated with Dr. Robert Mearns Yerkes back in the year 1900 when he was a graduate student and instructing psychology at Harvard University. In 1923, Dr. Yerkes began working with three young chimpanzees on his farm in New Hampshire. The following year he received an appointment to demonstrate the value of apes as laboratory animals. Two more pairs of chimpanzees were acquired and some of the animals now at Yerkes are descendants of these animals. The famous Rosalea D'Abreu in Havana, Cuba, who had a fine collection of apes, donated some of the animals to Dr. Yerkes' collection.

In 1930, Dr. Yerkes managed to obtain funds to move his colony from New Haven, Connecticut to Orange Park, Florida, and over the next 35 years the Yerkes Laboratories of Primate Biology became world famous for its studies of ape psychology and its implications for human mental processes. Other primate species were subsequently added to the Yerkes colony. These included additional great apes and in particular orangutans of which there are now over 30 in the colony and which are breeding so well that in the past two years we have had eight babies born at the Center. We also now have 15 gorillas,

and at one time there were also a number of Gibbons. There are now 400 types of monkeys incorporating 20 or more species.

Gift to Emory

Eventually, the Florida location of the Yerkes Laboratories of Primate Biology proved to be too remote for satisfactory administration from New Haven, and in 1956 Yale gave the Orange Park facility to Emory University. At this time there was a growing interest in primate research on the part of the National Institutes of Health, an agency of the U. S. Public Health Service, and this led to the allocation of funds for construction of seven primate centers. As the program developed, the Florida installation graduated into the Yerkes Regional Primate Research Center, and in the summer of 1965 the entire Yerkes complement, apes, monkeys, and people moved from Orange Park to the Emory Campus in suburban Atlanta. The new facilities were built at a cost of more than \$1,800,000 with a grant from the National Heart Institute of the National Institutes of Health. The main building was dedicated October 27, 1965, at which time Dr. Sanford S. Atwood, Emory president, called it the formal beginning of a great research operation in the field of biology.

Mission of the Center

The mission of the Yerkes Center is to study the biological and behavioral characteristics of non-hu-

PRIMATE CENTER / Bourne

man primates, particularly the great apes in relation to their environments; to investigate in these animals the possible reasons for physical, mental, and social disorders in human beings; and to explore such biological, behavioral, and environmental factors as may promote human health and welfare. The specific programs carried out at the Center depend upon the special skills and experience of the scientific staff and the opportunities offered by the unexcelled collection of great apes.

Variety of Species

At this moment the Yerkes Center has a total of 475 non-human primates representing more than 25 species. Of these, 123 are great apes including, as mentioned before, 15 gorillas, 33 orangutans, and 76 chimpanzees. Among the other primates represented are gelada baboons, mandrills, drills, a variety of *macaques*, and new world monkeys.

The health and maintenance of all animals are strictly supervised. When they arrive at the Center all are quarantined until they appear to be disease and parasite free—they are then admitted to the colony. Each animal is assigned an identification code, and a complete biography of each animal is kept by the animal records clerk.

The Yerkes Center has 24 full- and part-time scientists on its staff. Their specialties cover a wide range of disciplines from gross anatomy and physical anthropology through pathology, sociobiology, psychobiology, and immunology. Many research programs are inter-disciplinary. There are two clinical veterinarians who are responsible for the health of the animals, and they are assisted by a veterinary pathologist. All three also pursue independent scientific research programs.

Scientific Community

Every year many visiting scientists and students use the research facilities of the Yerkes Center. They may come for a day, a week, a month, or a year. All programs are in keeping with the aims of the Center to advance all possible areas of knowledge relating to primate research and to provide an optimal environment wherein resident and visiting scientists or students may actively pursue such research into accumulated knowledge with appropriate information from other institutions. In spirit and in fact the Center represents an integrated scientific community without geographic limitations.

In support of the investigators are 89 research assistants, technicians, laboratory aides, animal handlers, secretaries and clerks. Twenty-nine of these employees have the special task of handling and

caring for the animals. There is a librarian, a medical artist, an X-ray technician, a registered nurse, a photographer, and an electron microscope technician, and a number of other skilled laboratory technicians. The shop supervisor and his assistant build and maintain special equipment required for support of research. Operation and maintenance of the physical plant is the responsibility of the Emory University Maintenance Department.

The general public is not encouraged to visit the Center since they are capable of carrying diseases which could infect the animals and since the value of the animals is at least \$500,000 it would not be economically desirable to take such a risk. In the case of the Orangutan Colony it would be completely impossible to replace them at any cost if anything happened to them. Some visitors are permitted, but they are mostly scientists and students with particular research or training needs.

Financing the Center

The Yerkes Center is financed through a continuing operating grant from the Division of Research Facilities and Resources of the National Institutes of Health and through project grants funded by various divisions and institutes of National Institutes of Health, the National Aeronautics and Space Administration, the National Science Foundation, National Heart Institute, National Institute of Mental Health, etc. The total operating budget of Yerkes for the year 1968-69 is in the nature of \$1.3 million. This includes both the operating and the project grants and also supplementary gifts and grants.

The Yerkes Primate Center is unique among primate centers in being largely concerned with studies on great apes. This does not, of course, exclude interest in or studies on other primates, as may be seen by the wide variety of monkeys and apes which we possess. In many cases, of course, procedures and techniques need to be perfected in less expensive primates before being applied to the more expensive great apes. Comparative investigations require the use of selected members of all major primate taxa, and certain types of investigation are more appropriately carried out on lower primates.

Field Station

Twenty-five miles to the northeast of the Center along Highway I-85 there is a 115-acre field station which includes a number of large outdoor enclosures for housing monkeys and apes. Special types of study are carried on there with particular reference to sociological relationships between animals living in groups in a more or less semi-free environment.

One of the units at the Yerkes Center is the his-

tology and histopathology unit which is under the direction of Dr. Charles Graham. This provides a histological service to the Center as a whole and in particular to the veterinary pathologist in connection with the studies of primate diseases. As part of this work a collection of stained microscopic preparations of the normal and pathological primate tissues is being assembled. The research programs in this unit are concerned with the female reproductive system and include histochemical and histological studies of the effects of estrogens on the squirrel monkey uterine cervix. Other associated studies include the investigation of great ape reproductive endocrinology, of pleuropneumonia-like organisms and old-age pigment in squirrel monkeys and other species of primates.

Department of Immunology

The Department of Immunology shares its professional staff with Duke University. Doctors Metzgar and Zmijewski are studying the isoantigens of great ape blood cells with relation to the problem of human organ transplantation. Because the great apes possess many antigens that are identical to those found in man, these animals are also being used in studies of human tumor antigens and auto-immune diseases. Doctors Metzgar and Zmijewski are on the staff of the Department of Microbiology of Duke University and are also part-time members of the staff of the Yerkes Center.

There is also a laboratory for Histochemistry and special Pathology at the Center. In this laboratory studies are being carried out under the direction of Dr. Golarz on the development on atherosclerosis in the chimpanzee and the enzyme changes which take place in the aorta in its course of development and also on studies in an attempt to suppress these changes with the aid of unsaturated fatty acids. In addition to the atherosclerosis program, studies are taking place on the attempt to induce muscular dystrophy-like changes in monkey muscle by auto-immune procedures, i.e., by the injecting back into an animal of homogenates of its own muscle. This unit is also intimately concerned in a program in collaboration with the Space Agency and with the Navy. This project is intended to place two Rhesus monkeys in orbit for a period of six months to one year and on their return one animal will be sacrificed and an intensive histopathological, histochemical study will be made of its tissues in an attempt to determine the adverse effects of zero gravity.

Psychobiological Unit

There is also a psychobiological unit, and the mission of this unit is to study the behavior of the

animals in the colony and of animals subjected to certain drugs or environmental procedures. Doctors Richard Davenport and Charles Rogers are involved in the long-term program studying the effects of differential rearing experiences. This project is concerned with a number of young chimpanzees which were taken away from their mothers at birth and reared for twenty months in a state of complete isolation. They saw neither animals nor human beings during this time and heard very little noise. They were fed more or less automatically and their hygiene was taken care of more or less in the same way. These animals are now six or seven years old and are showing all kinds of mental abnormalities, including some such as stereotypy which is similar to that found in some mentally retarded children. They are also showing some signs which are suggestive of schizophrenia.

Brain Telestimulation

The Neurophysiology Unit in the Center investigates brain behavior relationships pertinent to adaptive emotional and motivational behavior. Research is anatomically centered mainly on the limbic system. There is a program particularly concerned with brain telestimulation associated with evolved social responses. In other words, they have succeeded in localizing part of the brain with the probes that they pass into the interior of the brain which upon stimulation electrically will induce aggression in the animal.

The stimulation of the electrode is carried out via a small radio receiving set cemented to the animal's skull and has a very ingenious switching mechanism associated with it which was designed by Professor Warner, a member of the faculty of the Center. This mechanism enables the investigator to switch by radio to stimulation of any one of 12 separate electrodes which are implanted in the animal's brain. Professor Warner is also interested in the development of a glucose fuel cell which would be implanted into an animal and would draw power from body fluids and would be used for such purposes, for example, as a cardiac pacemaker.

Neurohistochemistry

There is also a section called Neurohistochemistry, staffed by Drs. Manocha and Shantha, which not only studies the distribution of enzymes in the brains of different primates, but is also concerned with the neuroanatomy. This unit has recently published a stereotaxic atlas on the brain of the Java Monkey and another one on the Rhesus Monkey, and they

PRIMATE CENTER / Bourne

have recently done a detailed study of the chimpanzee brain. Currently, they are investigating the effects of keeping animals in continuous light or dark on the intensity and distribution of enzymes in different parts of the brain.

There is a Department of Gross Anatomy and Physical Anthropology, and this is headed by Dr. Osman Hill who has to his credit seven volumes on primate anatomy. He carried out a series of detailed anatomical studies in his section and is also particularly interested in the keeping and breeding of certain rare primates such as some of the South American Marmosets.

There is also a unit called Neuroanatomy and Optic Physiology which is headed by Dr. Johannes Tigges, formerly from the Max Planck Institute for Brain Research in Frankfurt, Germany. He is particularly interested in the accessory optic system and its anatomical integration into the central nervous system. He is comparing this system over a wide range of primates and other selected mammals. Apparently, one of the areas into which the accessory optic system goes is that of the pineal. The Optic Physiology section of this unit is also recording electroretinograms from the eye, particularly concentrating on long-lasting effects and developing techniques to record potentials from single cells and from units of the optic centers in the eye.

Projects in Sociobiology

The Department of Sociobiology includes Dr. Irwin Bernstein who works at the Field Station and Dr. Stuart Altmann who is particularly concerned with the studies in the field, particularly of baboons. Dr. Bernstein is interested in the interrelation of social processes in captive and wild populations of primates and in the behavioral, social, and ecological variables in primates and their adaptation to the problems they face in their natural habitats and under cage conditions. The nature of species difference in social organization and their adaptations and their implications for different groups of primates are also being considered. Some of the research is concerned with social communications in primates, and in Dr. Altmann's case, in the development of mathematical models of social and ecological processes.

The Department of Veterinary Medicine has Dr. Michael Keeling and Dr. Gary Moore as its members. Their primary concern is, of course, the well-being of the animal colony, but they are interested in various types of research. One of the most important of these is the establishment of baseline norms for different primate species, and this in-

cludes the hematology, blood chemistry, and the excretion in the urine of certain steroid compounds. This unit is also responsible for the ape breeding program which is particularly successful. In the past two years, for example, we have bred eight of the very rare orangutans and some eight to ten chimpanzees. They also have concern, in a collaborative way, with some of the other programs going on in the Center and are collaborating with outside scientists in other programs.

Pathology Unit

The Pathology Unit is under the direction of Dr. Harold McClure, a veterinary pathologist, who does the pathology services required by the Center and also carries out a series of related researches. He is particularly interested in the group of Air Force Rhesus monkeys which were subjected to atomic radiation in the 1950's and which are now being monitored for the development of leukemia and other malignancies, and he is also cross-breeding them to study the possible development of birth defects. He is also particularly interested in the transmission of leukemia both from dogs to primates and from the milk of leukemic cows to primates.

Dr. McClure also controls the hematology laboratory, the clinical biochemistry laboratory, and the electron microscopy laboratory. Also, under his supervision is the cytogenetics program. A cytogenetics technician has been recently employed and she is making a study of the chromosomes of the various species of primates and the irradiated monkeys, and also of the animals on which experimental procedures have been carried out.

The list of projects which have been discussed represents only a small fraction of the total program of the Center. There are many collaborative programs with Emory University and we share some of our Faculty with Emory University. There are also collaborative programs with other Universities and with institutions in other countries in the world. I think it can be truly said that the great ape collection at the Yerkes Primate Center represents a national resource and one of incomparable value in health and medical research.

954 Gatewood Rd., N.E.

Second Annual

COMMITTEE CONCLAVE

July 26-27, 1969

Marriott Motor Hotel

Atlanta, Ga.

Favorable results are reported with the use of this broad spectrum antibiotic in 97 pediatric outpatients.

Clinical Investigation of the Use of Doxycycline in Infections of the Respiratory Tract in Children

FOREST JONES, M.D., *Atlanta*

IN THE PAST 20 YEARS, since chlortetracycline was discovered in 1948, six distinct tetracycline agents have been introduced into chemotherapy. From one of these analogs, oxytetracycline, two semi-synthetic antibiotics have recently been produced. The first of these was methacycline, from which the most recent, doxycycline, has been synthesized by a process of hydrogenation.

Doxycycline* (α -6-dioxyoxytetracycline) is reported¹ to display highly satisfactory absorption and tissue distribution in animals. Also as a result of animal studies, this new agent has been favored² over methacycline, demethylchlortetracycline, and tetracycline. Further experimentation using animals has shown³ that doxycycline offers superior maintenance of antibiotic serum concentrations, as well as speed in reaching the necessary level for activity in the host.

Colmore et al.⁴ have reported clinical evidence of doxycycline's value in treatment of urinary tract infections caused by gram-negative organisms; these investigators found, in this context, that the drug compares favorably with nitrofurantoin, chloramphenicol, ampicillin, nalidixic acid, kanamycin sulfate, sulfonamides, and various other tetracyclines.

The present paper describes a clinical study of 97 pediatric outpatients treated with doxycycline in therapy for infections of both the upper and lower respiratory tract.

Methods and Materials

For the purposes of clinical evaluation of doxycycline, 97 pediatric outpatients were admitted to a

study of chemotherapy for various infections of the upper and lower respiratory tract. These 58 males and 39 females ranged from one month to 12 years in age; their average age was three years and 10 months.

Bacterial cultures were conducted, both before and after doxycycline therapy, in all 97 cases. Susceptibility tests, using the disc method, were conducted on all positive cultures for doxycycline, as well as for tetracycline, penicillin, erythromycin, chloromycetin, and in some cases for lincocin.

Of the 97 patients in the present study 88 received doxycycline in the syrup form, in dosages determined by body weight; the nine remaining subjects received 50 mg. capsules of the drug. Dosages on the first day of doxycycline therapy ranged from 2 to 4 mg./lb. twice daily. Maintenance dosages ranged from 1 mg./lb. once a day to 2 mg./lb. twice a day; most (72) subjects were maintained on either 1 or 2 mg./lb. once daily.

Duration of Medication

The duration of test medication for subjects showing favorable responses to doxycycline ranged from four to 14 days; the mean duration of chemotherapy during the study period was 10 days. It should be noted that all subjects whose cultures proved positive for *Streptococcus* organisms routinely received at least eight to 10 days' therapy to prevent development toward rheumatic fever or glomerulonephritis. Eleven of the present subjects had received antibiotic medication other than doxycycline prior to the beginning of the present study. Medication adminis-

* Vibramycin ®, Pfizer Laboratories.

tered concomitant with doxycycline was limited to antihistamines and nose drops as required; no other antibiotic agent was employed during the study period.

Responses to doxycycline therapy were evaluated according to the following criteria:

Good—a definite favorable response with a prompt alleviation of symptoms.

Satisfactory—a beneficial response but the symptoms persist for a longer period than might be expected with a good response.

Poor—no response or a worsening of symptoms.

Results

The most common infections encountered in the present study group were: otitis media, 23 cases; tonsillitis, 25 cases; and pharyngitis, 26 cases.

TABLE I CLINICAL RESPONSE TO DOXYCYCLINE THERAPY				
Acute	Diagnosis	Good	Satis- factory	Poor
	Pneumonia, single lobe	3	—	—
	and bilateral otitis media	1	—	—
	Pneumonia, multilobe	2	—	—
	Broncho-pneumonia, single lobe	1	—	—
	Broncho-pneumonia, multilobe	6	—	—
	Bronchitis	1	—	—
	and pharyngitis	—	1	—
	and otitis media	—	—	1
	and chronic tonsillitis	—	1	—
	Pharyngitis	2	—	—
	and scarlet fever	1	—	—
	and tonsillitis	11	1	1
	and scarlet fever	1	—	—
	and otitis media, unilateral	1	—	—
	bilateral	6	—	—
	and tonsillitis with otitis media, bilateral	2	—	—
	Tonsillitis	20*	—	1
	and otitis media, unilateral	—	—	1
	bilateral	3	—	—
	Otitis media, unilateral	11	—	2
	bilateral	6**	—	1
	Laryngotracheitis	2	—	—
	Cervical adenitis	—	1	1
Acute Chronic				
	Bronchitis, asthmatic	—	1	—
Recurrent				
	Otitis media, unilateral	1	—	—
	bilateral	1	—	—
Chronic				
	Otitis media	—	—	1
	Cervical adenitis	1	—	—
TOTAL		83	5	9

* One patient relapsed 4 days after completing doxycycline therapy.
** One patient had a ruptured tympanum before starting doxycycline therapy.

TABLE II DIAGNOSIS AND RESPONSE TO DOXYCYCLINE THERAPY RELATED TO BACTERIAL CULTURE								
Acute	Response to Doxycycline	Staph. Aureus +	Staph. Aureus -	β-H. Strep.	Pneumococcus	Pseudomonas	Strep. pyog.	No growth
Bronchopneumonia, single lobe	G	1			1			
Bronchopneumonia, multilobe	G	1		3	1		1	
Pneumonia, multilobe	G			1				1
Pneumonia, single lobe and otitis media, bilateral	G	1		1				1
Bronchitis	G	1						
and tonsillitis chronic	S	1						
and pharyngitis ...	S		1					
and otitis media ..	P							1
Pharyngitis	G							1
and scarlet fever ..	G			1				
and tonsillitis	G	3	1	7				
	S	1						
	P				1			
and scarlet fever ..	G			1				
and otitis media ..	G			1				
bilateral	G	2		3	1			
and tonsillitis, otitis media bilateral ..	G				2			
Tonsillitis	G	7	1*	10				2
	P	1						
and otitis media ...	P							1
bilateral	G			3				
Otitis media	G	2		1	3	1		11
	P			1				
Laryngotracheitis ...	G							2
Cervical adenitis ...	S			1				
bilateral	G							1
Acute Chronic								
Bronchitis, asthma ..	S							1
Recurrent								
Otitis media	G							1
bilateral	G							1
Chronic								
Otitis media	P			1		1		
Cervical adenitis	G	1						
TOTAL		22	3	39	7	2	1	25

Note: Two patients each cultured 2 bacteria.
* Relapse 4 days after Vibramycin.

Table I lists all diagnoses, their nature (acute, recurrent, or chronic) and the clinical response of each subject to doxycycline therapy. It will be seen that all but five of the present subjects were treated for acute infections. Eighty-three showed *good* responses, five *satisfactory*, and nine *poor*.

Clinical Response

Diagnoses and clinical response are shown, in Table II, in relation to the appropriate bacterial cultures identified in each case. The most common

of the microorganisms in evidence were β -hemolytic *Streptococcus* and *Staphylococcus aureus*. Of the 39 patients whose cultures were positive for β -hemolytic *Streptococcus*, the clinical response was *good* in 34, *satisfactory* in one and *poor* in the remaining four. Of the 25 subjects whose infections were related to *Staphylococcus aureus* strains, clinical response was *good* in 21, *satisfactory* in three, and *poor* in one.

Table III shows the results of comparative susceptibility tests, using the disc method, conducted for doxycycline and several other antibiotic agents. These tests showed an appreciable *in vitro* superiority of doxycycline and chloromycetin over tetracycline, penicillin, erythromycin, and lincocin. The *in vitro* effectiveness of doxycycline in inhibiting these organisms appeared to be borne out clinically, as the aforementioned findings suggest.

Eleven subjects with acute infections (pneumonia, bronchopneumonia, pharyngitis and/or tonsillitis, and otitis media) displaying a good response to doxycycline had failed to respond satisfactorily to various other antibacterial preparations (penicillin, benzathine penicillin G, sulfasoxazole, sulfamethoxazole, a trisulfapyrimidine formulation, tetracycline-amphotericin B, and oxytetracycline).

Six patients with acute tonsillitis and/or otitis media failed to respond to doxycycline but improved with sulfasoxazole (5 cases) or benzathine penicillin G.

A case of otitis media of six months' duration failed to respond to various antibacterials, including doxycycline. A resistant *Pseudomonas* strain was cultured from the ear drainage.

A two-year-old male with acute tonsillitis failed to respond to treatments with intramuscular penicillin, erythromycin and doxycycline. A resistant *Staph. aureus*, coagulase positive, was cultured. The child was hospitalized and responded to treatment with sodium oxacillin.

Reduced Fever

Eighty-five of the present 97 subjects presented elevated temperature readings at the start of this study. Fourteen of these subjects' temperatures had returned to normal within 12 hours after the start of therapy. Another 33 showed normal temperatures after 24 hours of treatment. At the end of 48 hours of treatment with doxycycline all but eight of these 85 patients' temperatures had been brought within the normal range.

Side Effects Noted

In the course of the present study, there were several instances of nausea, some accompanied by vomiting. These appeared to result directly from the infections involved with two possible exceptions, as follows: One subject, a five and a half-year-old boy, experienced mild nausea, without vomiting, after each dose of doxycycline starting on the third day of medication; these episodes lasted between 30 and 60 minutes. Also, a six-year-old girl with pneumonia regurgitated the medication twice on both the first and second days of treatment, but retained all subsequent days' doses. These were the only side effects that might be attributed to the test medication. Hematologic tests, conducted in 88 cases both before and after doxycycline therapy, revealed that 59 patients showed a decrease in neutrophils and an increase in lymphocytes, and that eight other patients had increased eosinophils.

Summary

Doxycycline, a new antibiotic agent, was evaluated for efficacy in respiratory infections in 97 pediatric outpatients. The average age of the subjects was slightly less than four years. The most common primary diagnoses were pharyngitis, tonsillitis, and otitis media. The most common microorganisms

TABLE III
COMPARATIVE SUSCEPTIBILITY TESTS

	Doxycycline		Tetra- cycline		Peni- cillin		Erythro- mycin		Chloro- mycetin		Lin- cocin	
	S	R	S	R	S	R	S	R	S	R	S	R
<i>Staph. aureus</i> (pos.)	21	2	17	6	5	18	20	3	22	1	5	2
<i>Staph. aureus</i> (neg.)	2	—	2	—	1	1	1	1	2	—	—	1
<i>B-hemolytic Strep.</i>	40	—	33	7	38	2	35	9	39	1	7	3
<i>Pneumococcus</i>	6	—	5	1	6	—	6	—	6	—	2	—
<i>Pseudomonas</i>	1	1	1	1	—	2	—	2	—	2	—	1
<i>Strep. pyogenes</i>	1	—	1	—	—	1	1	—	1	—	1	—
TOTAL	71	3	59	15	50	24	63	15	70	4	15	7

DOXYCYCLINE / Jones

cultured were β -hemolytic *Streptococcus*, and *Staphylococcus aureus*.

Eighty-three of the subjects had *good* responses to doxycycline therapy; five had *satisfactory* responses; and in nine cases clinical response was noted as *poor*. Doxycycline appeared especially effective in that it obtained *good* or *satisfactory* response in 35 of the 39 cases of β -hemolytic *Streptococcus* infection, as well as obtaining *good* or *satisfactory* clinical responses in all but one of the 25 subjects whose infections were related to *Staphylococcus aureus* strains.

Present findings indicate that doxycycline can be expected to produce definite improvement, with the

speed desired in such cases, and with the necessary margin of safety, in chemotherapy for both upper and lower respiratory tract infections in pediatric patients.

710 Peachtree St., N.E.

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COURSE SCHEDULED ON EMERGENCY CARE

A four-day course on emergency care and transportation of sick and injured persons will be held in Atlanta June 4-7 at Georgia State College, 33 Gilmer Street, S.E.

Sponsored by the American Academy of Orthopaedic Surgeons, the course is designed for ambulance attendants, nurses, firemen, policemen, safety engineers, rescue squads, and others who work with persons requiring emergency attention.

Introduced in Atlanta last year, the comprehensive training meeting was attended by rescue and health experts from Atlanta and 44 other cities in 10 States. With faculty members of Emory University School of Medicine, the June lectures and work practice sessions will be given in cooperation with the Fulton County Medical Society, the Greater Atlanta Traffic and Safety Council, and Georgia State College.

To furnish this instruction, Atlanta area physicians, Emory faculty members, members of the Atlanta Fire and Police departments, and others will speak and demonstrate on a wide range of subjects, including shock, resuscitation, cardiac massage, wound dressing,

splinting of fractures, and other medical emergencies. Emergency childbirth, burns, aid to poison victims, electrical safety, and even the legal aspects of emergency transportation will be discussed. Demonstrations of how to extricate victims from crushed autos and use of rescue equipment will also be given.

The course is one of a series of comprehensive training courses being conducted in major cities by the Academy's Committee on Injuries, whose Chairman is Dr. George E. Spencer, Jr., Cleveland.

Members of the Program Committee for the Atlanta course are Dr. Robert E. Wells, Atlanta orthopaedic surgeon who organized the program, chairman; and Drs. Frederick A. Carpenter, associate professor of anesthesiology, Emory; E. Ladd Jones, clinical instructor in orthopaedic surgery, Emory; Brown W. Dennis, Atlanta cardiologist; Arthur M. Kaplan, Atlanta attorney, and Lt. Lewis A. Pendergrass, Atlanta Police Department.

For information and registration forms, those interested may write to Robert E. Wells, M.D., 1938 Peachtree Road, N.W., Atlanta, Georgia 30309.

NEUROLOGY AND THE INTERNIST IS ACP COURSE TOPIC

The American College of Physicians announces a postgraduate course on "Neurology and the Internist," to be held June 11-14 at the Bowman Gray School of Medicine in Winston-Salem, N.C.

This course has been designed to provide internists and family physicians with practical information which will be useful in diagnosis and treatment of the many neurological problems encountered in their patients. Emphasis will be on diagnosis of the cause and management of various pain syndromes, the neurologic manifestations of systemic diseases such as cerebrovascular disorders, and neuro-endocrine diseases. Sem-

inars, patient presentations, round table discussions and clinicopathologic conferences will be emphasized to encourage audience participation.

All meetings will take place at the Robert E. Lee Hotel. Co-directors for the course are James F. Toole, M.D., F.A.C.P. and Richard Janeway, M.D. The fee for A.C.P. members is \$60; for non-members, \$100.

All registrations, requests for information and application should be addressed to Edward C. Rosenow, Jr., M.D., F.A.C.P., Executive Director, American College of Physicians, 4200 Pine Street, Philadelphia, Pa. 19104.

This newly marketed agent has a wide range of usefulness, if proper precautions are taken.

Clinical Applications of Inhibition of Beta-Adrenergic Receptors With Propranolol

MORRIS STAMPFER, M.D.,* *Bronx, N.Y., and* STEPHEN E. EPSTEIN, M.D.,† *Bethesda, Md.*

PROPRANOLOL, THE FIRST clinically useful beta-adrenergic blocking drug, was recently placed on the market after several years of exhaustive clinical trials. On the basis of many investigations, it appears that blockade of the beta-adrenergic receptors may be useful in the treatment of several types of cardiac problems. However, as with any potent drug, the physician must possess full knowledge of its mechanism of action and possible hazards before prescribing. This article is intended as a brief survey of the actions and uses of propranolol for the practicing physician.

Pharmacology

The work of Dale, Ahlquist and others has established the existence of different types of responses to adrenergic stimulation, dependent on the presence of either of two types of receptor sites in the tissues. For example, stimulation of alpha-adrenergic receptors causes constriction of blood vessels, while stimulation of beta receptors causes vasodilation. Only beta receptors are located in the heart, and stimulation of these receptors results in an increase in the heart rate and the force of cardiac contraction.

The endogenous catecholamines, epinephrine and norepinephrine, stimulate both alpha and beta re-

ceptors, while the catecholamine isoproterenol stimulates beta-adrenergic receptor sites exclusively. Although alpha-adrenergic blocking drugs have been known for many years, propranolol is the first generally available drug which antagonizes the action of catecholamines at the beta-adrenergic receptor sites, thus causing slowing of the heart rate and a decrease in the force of cardiac contraction.

Clinical Uses

Angina pectoris is due to a disproportion between the O₂ requirements of the myocardium and the O₂ supply so that the supply of oxygen is inadequate to meet myocardial metabolic demands. In theory, angina can be relieved either by increasing oxygen delivery or decreasing metabolic requirements. Since both heart rate and the force of contraction are important in determining the amount of O₂ required by the heart, propranolol, by decreasing these parameters during exercise, is often successful in relieving angina that is refractory to the more commonly used drugs.

The dose required is highly variable and is best ascertained by starting with a small dose such as 10 or 20 mg. by mouth four times daily, and increasing gradually until attacks of angina are substantially reduced in frequency. Doses of 400 mg. daily or more have occasionally been used, although the most commonly required dosage ranges from 120 to 240 mg. daily.

* Associate in Medicine, Albert Einstein College of Medicine, Bronx, New York.

† Acting Chief, Cardiology Branch, and Chief, Section on Circulatory Physiology, Cardiology Branch, National Heart Institute, Bethesda, Md.

Very close observation of the patient is necessary since congestive failure may appear. Such symptoms may often be controlled with Digitalis glycosides and diuretic agents. However, if these interventions are not successful in controlling symptoms of failure, propranolol must be discontinued.

Treating Arrhythmias

Propranolol can be used in the treatment of various cardiac arrhythmias; its beneficial effects are due not only to beta-adrenergic blockade, but in certain arrhythmias to a quinidine-like action as well.

Propranolol may abolish arrhythmias caused by digitalis intoxication, including frequent premature ventricular contractions and ventricular tachycardia. It should be stressed, however, that there is no evidence that propranolol is superior to some of the other commonly used antiarrhythmic agents.

In arrhythmias not due to digitalis, such as atrial fibrillation or atrial flutter with rapid ventricular response, propranolol usually can be relied upon to slow the ventricular rate. Recurrent attacks of paroxysmal atrial tachycardia may occasionally be reduced in frequency or prevented by propranolol, although sufficient information to assess long-term results is not yet available.

Emergency Treatment

When emergency treatment is required, propranolol should be given intravenously in doses of not more than 0.5 mg. every three to four minutes until the desired effect is achieved or signs or symptoms of worsening cardiac decompensation are noted. The drug should not be used in complete atrioventricular block with idioventricular rhythm (unless a cardiac pacemaker is in place) since electrical activity may be slowed further or arrested.

Treating IHSS

Propranolol has been found to be beneficial in many patients with idiopathic hypertrophic subaortic stenosis (IHSS). The exercise tolerance of patients whose primary symptom is angina pectoris has been improved by propranolol, and the frequency of syncopal episodes and of arrhythmias can be reduced in other patients. The reason for this improvement probably is due to the fact that obstruction to left ventricular outflow in IHSS is made worse by drugs or maneuvers that increase the contractile state of the heart, such as isoproterenol or exercise. Propranolol, by decreasing sympathetic stimulation of the heart, decreases this obstruction. This change is less marked at rest, when there is normally little

sympathetic stimulation present, but becomes more significant during exercise.

It should be stressed that in patients with IHSS and congestive failure, the drug may produce deleterious effects, just as in patients with other types of heart disease who have signs and symptoms of cardiac failure.

Side Effects and Contraindications

By interfering with sympathetic stimulation to the heart, propranolol decreases the cardiac output response to exercise in normal subjects, and thereby impairs their capacity to perform intense exercise. This finding demonstrates the significant role of the sympathetic system in the cardiac response to the stress of exercise.

Propranolol also alters the diurnal pattern of sodium excretion in normal subjects and in patients with mildly impaired cardiac function. However, in patients with severe cardiac decompensation its administration may cause frank retention of sodium and fluid, changes resulting in progressive edema accumulation and symptomatic deterioration. Thus, in patients with heart disease whose cardiac reserve is diminished and who depend upon sympathetic support to maintain compensation, inhibition of cardiac sympathetic stimulation may lead to severe and sometimes irreversible symptoms of cardiac failure.

Other major side effects that have been reported are severe hypoglycemic reactions occurring in patients taking insulin or oral hyperglycemic agents, and acute pulmonary insufficiency due to bronchospasm, a complication that may occur in patients with obstructive airway disease.

Summary

Blockade of the beta-adrenergic receptors is of significant benefit in selected patients with various types of heart disease. Angina pectoris, digitalis-induced arrhythmias, atrial fibrillation and flutter, and idiopathic hypertrophic subaortic stenosis are conditions in which this drug may be useful. However, caution and continued close observation of the patient is always necessary because removal of sympathetic support to the failing heart may result in severe cardiac decompensation. Propranolol and other beta-adrenergic blocking drugs should not be administered to patients with congestive heart failure that does not respond to digitalis glycosides and diuretics, and to patients with atrioventricular block, unless a cardiac pacemaker is in place. In addition, they should be given with extreme caution to patients with obstructive airway disease and to patients taking insulin or oral hypoglycemic agents.

Cardiology Branch, National Heart Institute

*A discussion of the evolution of the bones
of the hand in various vertebrate
species.*

Notes on the Peculiarities of the First Metacarpal and the First Metatarsal Bones

RICHARD TORPIN, M.D., *Augusta*

ABOUT 40 YEARS AGO when my youngest daughter was six years old, she got her finger mashed by a closing automobile door. I took her to my office and made a radiograph of her hand. While there was no evidence of bone injury, I noticed that the first metacarpal bone had the epiphyseal configuration of the phalanges and not at all as in the other four metacarpals. (Note Figure 1.) Subsequently, at meetings of the American Association of Anatomists I spoke to several members in respect to this observation, but without eliciting much interest.

On further investigation I found that roentgenologists are familiar with this condition in the juvenile hand (and also in the homologous bones of the foot). (Note Figure 2.) The fact usually is ignored in the texts. Furthermore, no notice of this is made by paleontologists whose works I have read.

From such (paleontological) studies one may observe that pentadactylism became a fairly general attribute of vertebrate amphibious animals early in the paleozoic Devonian period, possibly nearly half a billion years ago. An early associate of pentadactylism apparently was the atrophy of the first metacarpal which likewise occurred in the first metatarsal. From illustrations of the distal extremities of all primates, including shrews, lemurs, monkeys, apes and humans, it seems to be apparent that the same situation exists in all. In some of the other primates the foot is almost as facile as the hand.

All of these, as well as all land animals having some use for a prehensile extremity, generally retain the five digit arrangement. In general the heavier terrestrial, browsing animals had a tendency to

atrophy of one or more digits, representing extreme specialization in this respect.

Related to Phalanx

There might be additional evidence that the first metacarpal bone is derived from a phalanx rather than being originally a true metacarpal. Spalteholz in his *Hand Atlas of Human Anatomy*, noted that the nutrient arteries enter through the calcareous shell of bone in a direction distally from the arm, as in the phalanges and directly opposite to that in the other four metacarpals. In respect to the nutrient arteries of the foot, he indicated that a similar situation was present.

Anson (Morris' *Human Anatomy*, 12th ed. 1966) stated that the nutrient artery, in respect to the first metatarsal, situated laterally about the middle of the body, is directed toward the head of the bone, a direction contrary to the rule for the other metatarsals. He noted a similar situation in the first metacarpal.

With low magnification I made observation of the metacarpals, metatarsals and phalanges of ten skeletons without being able to discover much uniformity in the distribution of the nutrient artery openings in the bone. Some were single but the majority were very fine and multiple. The site and direction of the penetration varied hopelessly.

Likewise the studies of Wood Jones (1949) and of Singh (1960) each on 100 sets of metatarsal bones revealed not much consistency in the distribution of the nutrient arteries.

Other Evidence

There is a third piece of indirect evidence. It is obvious that a bone and a joint have been lost in the thumb and in the great toe. It is inconceivable that

From Department of Obstetrics and Gynecology and Department of Anatomy, Medical College of Georgia, Augusta.

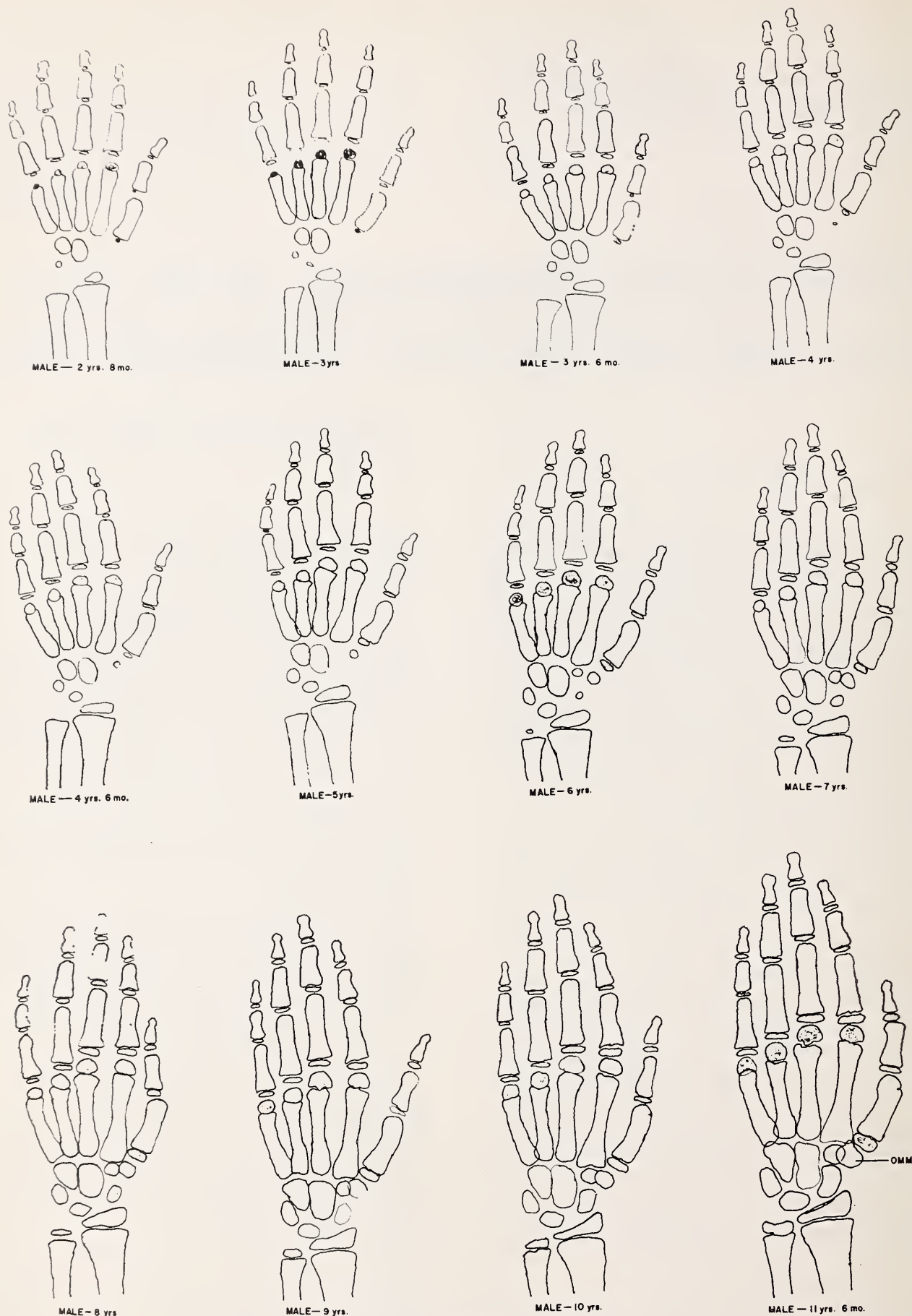
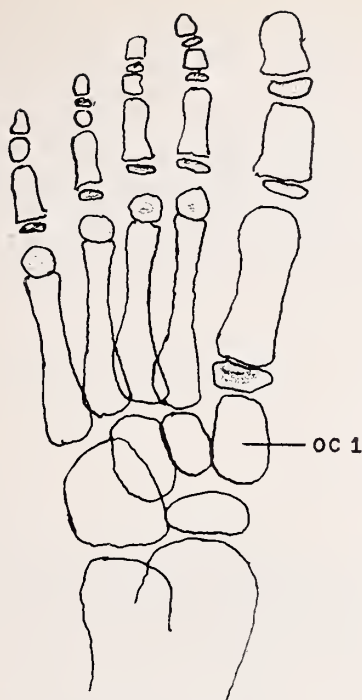


FIGURE 1

Series of radiographs of the juvenile hand, aged 2½ yrs. to 11½ yrs. Adapted from Greulich and Pyle: Radiographic Atlas of Skeletal Development of the Hand and Wrist. A similar series has been presented by Meschan: An Atlas of Normal Radiographic Anatomy. He also included a series of the foot. For the monkey (*macaca mulatta*) a serial study has been made by van Wagenen and Asling in the American Journal of Anatomy, 1964. This shows the epiphyseal arrangement to be identical to that of man. (Redrawn with permission of the publisher from Radiographic Atlas of the Skeletal Development of the Hand and Wrist by William W. Greulich and S. Idell Pyle, Stanford: Stanford University Press, 1959.)



MALE FOOT— 7 yrs.

FIGURE 2

Radiograph of a juvenile foot, showing bones and epiphyses, and demonstrating that the first metatarsal bone may be an oversized phalanx. (Courtesy of Department of Roentgenology, Medical College of Georgia.)

any relatively immobilized metacarpal (or metatarsal) bone could be likely to achieve the diverse motions capable in a phalanx, especially when a phalanx was already attached and readily available. Other bones have been known to disappear in the evolutionary scale: vertebral bones in the loss of a tail, and in some animals the complete absence of the clavicle.

By shortening the first digit it became more useful in grasping in unison with the other digits. Likewise the power developable at its distal end was multiplied by the reduction in length. The other four digits acting as a unit, opposed to the thumb, did not require shortening to increase their power.

Epiphyseal Distribution

The older anatomy books make no mention of the situation. However, since the introduction of X-rays the newer editions take note of the apparently anomalous epiphyseal distribution, especially in the metacarpal bones. Gray's Anatomy (27th edition, 1957), illustrates the epiphyses in both, juvenile metacarpal and metatarsal bones, adding a note that some anatomists hold that the thumb has three phalanges rather than only two.

Grant illustrated the epiphyseal assortment in the metacarpals and phalanges. He stated that the first metacarpal behaves as a phalanx. No mention is made of analogous epiphyseal distribution in the metatarsal bones. Anson also noted that the first

metacarpal bone has many of the characteristics of a phalanx.

The first metacarpal bone has the shape and contour of a phalanx, not at all like those of the other four metacarpals. Likewise the first metatarsal has the unique appearance of an overgrown phalanx, very dissimilar to the other metatarsals.

Atrophied Metacarpal Bone

It is postulated that the first metacarpal bone, probably several hundred million years ago was gradually atrophied into the os multangulum majus (new terminology: os trapezium). Likewise and simultaneously the first metatarsal was atrophied and became the os cuneiforme 1 (new terminology: os cuneiforme mediale). (Note Figure 1.)

A modern turtle has the hand and foot bones analogous to that of man and the other primates, but doesn't seem to make any special use of the first digit. All of the twenty digits are armed with sharp, curved claws which dig into the terrain equally. It appears to effect locomotion by rising up on the distal portion of its four extremities.

The presumed slow reduction of these two bones in the earliest vertebrates may be of value for investigation by the paleontologists. It may be possible, but not likely, that such studies may reveal the graduated atrophy of the first metacarpal (as well as that of the first metatarsal). This took place so early in vertebrate development that the evidence probably may be obliterated.

This subject has not been discussed further in any works on paleontology, roentgenology or anatomy that I have read. Possibly future books and atlases pertaining to the bone development may integrate these ancient anomalies into the nomenclature. The first tool, a stone or a club, probably was picked up by chance, but the benefits of this initial step un-

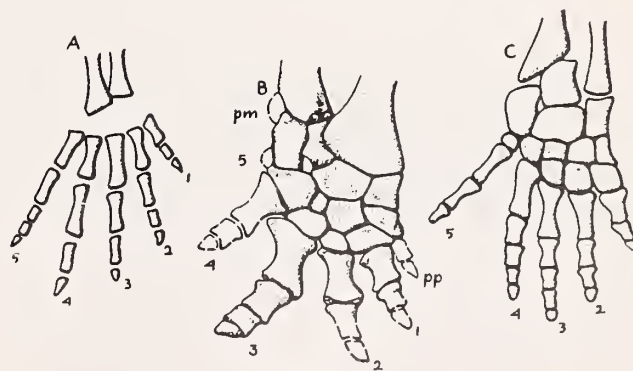


FIGURE 3

Copied from Romer: Vertebrate Paleontology, 3rd ed., 1966. The feet of amphibians. A. Manus of Diplovertebron, a small anthracosaurian; B. manus of the rhachitomous amphibian Eryops; C. pes of the Rhachitomous Amphibian Trematops. Abbreviations: pm, postminimus; pp, prepollex. (A after Watson; B after Gregory, Minor and Noble; C after Williston.) Reprinted by permission of the author and of the University of Chicago Press.

doubtedly stimulated the brain to devise and make use of more tools. These became more and more complicated with progress.

Man's hand and especially his thumb were the precursors and prime factors in the development of his brain. Likewise our immediate primate predecessors living in the trees acquired and bequeathed us binocular, long and short distance (microscopic) vision.

Probably the greatest single contribution received from our ancestors were the tree-developed thumbs. Otherwise we may have had the brains of the ungulates. Human brain power derives from the ability to manipulate and this very word originated from that for the hand. Inasmuch as the hand and especially the thumb are so closely associated with the development of the human brain, the subject merits attention.

Medical College of Georgia

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THE FEE FREEZE

A bill before the present Congress would constitute a freeze on fees charged by physicians to medicare if enacted. Senate Bill 111, introduced by Senator Aiken (R) Vermont, would amend the Social Security Act to provide that the program would pay no more for a medical procedure than the average payment for the same service under the State's Blue Shield allowance during the previous year. Senator Aiken has pointed out that under his bill all physicians would be required to take all their medicare patients on those terms.

Senate Bill 110

Earlier, Senator Aiken introduced Senate Bill 110 which would:

- (1) Remove all deductibles and co-insurance features under Title XVIII;
- (2) Permit women to qualify for medicare at age 62;

(3) Include payment for professional services by pathologists, radiologists, anesthesiologists, and psychiatrists under Part-A, hospital services;

(4) Permit referral of patients for care in extended care facilities from a hospital out-patient clinic, instead of requiring prior hospitalization;

(5) Authorize payment for one routine physical examination per year;

(6) Provide for payment of prescribed drugs (on a generic basis) under Part-B;

(7) Provide eye care and dental care.

In addition, Senate Bill 110 would authorize the Surgeon General to establish a schedule of fees for physician services based on community "prevailing fees." Both S. 110 and S. 111 have been referred to the Senate Finance Committee and the American Medical Association's Washington office will be following their progress.



A PHYSICIAN IS . . .

THIS TIME OF YEAR, when a new crop of freshly capped and freshly gowned young men and women leave the confines of the Halls of Ivy, armed with pieces of parchment stating that they are "Doctors of Medicine," is a good time to pause and consider just what this title or appellation means. To some it will mean the culmination of long hours, days, and years of work and at long last a chance to do good for his fellow man; to some a chance to capitalize on these hours, days and years of work and at last to stand on his own two feet and to be his own boss.

Like happiness, M.D. means different things to different people; to some it means about what we physicians would like it to mean; to some it means a necessary evil with whom they have to cope when things go wrong; to the cartoonist it means a great source of fresh material. When I recently was enrolled in the National Audubon Society as John Kirk Train, Maryland, I realized what M.D. meant to the secretary in charge of new subscriptions. So we see that M.D. does in fact mean different things to different people.

Having an uncreative mind, in writing these "President's Pages" during the coming year I will have to rely on quotations, and put down here things that others have said that express what I feel better than can my own words. Mostly, the quotes will be items turned up by my sharp-eyed, astute research staff, namely Ann Bradford Train, who has shared my bed and board for lo, these many years. Such a quote I put in here, written 25 years ago for the *Virginia Medical Monthly* by Dr. Beverly R. Tucker. The Tuckers of Virginia are legion, and not the least of these was Dr. Beverly R., whom I had the good fortune to know, and with whose sons I have through the years maintained more than a passing friendship. His words are still applicable today and should be read by all, as they say loudly and clearly what a physician is: "The best paid man in the world"!!!

The physician is the best paid man in the world. He is required to have an education which will be a benefit and a comfort to him all the days of his life. He wins a degree and he attains the honorable title of Doctor. He learns to know more intimately his fellow man than anyone else can know his fellow. He gets praise for many things that he does not deserve, and providence and disease are blamed for his mistakes. He wins the gratitude of those he serves. His charitable work is invaluable to his experience.

If he is reasonably conscientious and works hard, he builds a practice that will ensure him a good house, an office and an automobile, and enable him to rear and to educate a family and to stand the losses of the inevitably foolish investments he makes. If he has taste for invention there are innumerable unknown instruments

PRESIDENT'S LETTER / Continued

and improvements awaiting him. If he wishes to discover, the laboratory unfolds of-
portunities for him. If he likes research, the facilities and the libraries are available.
If he craves adventure, insidious dangers lurk around him and there are ever
pioneer fields to enter.

In his endeavors his government, his community, and his fellow physicians
stand ready to aid him. He is an advocate without a jury, a judge without a court,
a minister without a surplice, a businessman without guile, a farmer whose soil is
the human body and whose crops are human health and happiness, and he is a
laborer without a boss. The physician is the best paid man in the world.



John Kirk Train, M.D.
President, Medical Association of Georgia

MESSAGE FROM THE PRESIDENT

The important activities of the Medical Association of Georgia are carried out by appointed committees. Members are asked to contribute to their organization by checking one or more of the following committees on which they will be willing to serve. Send the signed form to the MAG Headquarters Office, 938 Peachtree Street, N.E., Atlanta 30309. Your help will be appreciated.

John Kirk Train, M.D.,
President, Medical Association of Georgia

Committees of the MAG

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	School Child Health	Crippled Children

(Name)

(Address)



THE PREVENTION OF VALVULAR HEART DISEASE

J. GORDON BARROW, M.D., *Atlanta*

THE AMERICAN HEART ASSOCIATION has wisely begun to emphasize the prevention of heart diseases as its major priority. The prevention of atherosclerosis and its complications is, of course, the highest priority; however, the prevention of valvular heart diseases should not be neglected. The two major causes of valvular heart disease, namely syphilis and rheumatic fever have been reduced markedly in the population by the widespread use of antibiotics. However, syphilis is on an upsurge at the present time, and a significant number of new cases of rheumatic fever continue to occur in the population.

Controlling Syphilis

Since syphilis occurs in all social classes and since Georgia has among the very highest rates in the country, we physicians in Georgia must become increasingly alert to this possibility in our patients. Testing of all possible suspects and their contacts is the only way that this disease can be brought under control. Since early and adequate treatment will totally prevent the valvular heart disease which results from syphilis, every effort should be made to identify all cases as early as possible.

Preventing Rheumatic Fever

The prevention of rheumatic fever may be divided into primary and secondary prevention. Primary prevention will be accomplished only if we follow the following principles: (1) All clinical pharyngitis should be cultured, preferably using a fluorescent antibody technic, and all infections proven due to Group A streptococcus should be treated with ten days of penicillin therapy (or 600,000 units of benzathine penicillin intramuscularly). (2) All infections clinically suspected of being streptococcal, such as erysipelas, scarlet fever, otitis media, etc. should be treated in a similar manner, even if positive cultures are not obtained. (3) All persons in closed population groups, such as military stations and boarding schools, should be given daily prophylaxis for one month with small doses of sulfadiazine or penicillin orally if a streptococcal epidemic is identified in that population.

Continuous Prophylaxis

Secondary prevention is the use of continuous prophylaxis in those persons in the population known to be susceptible to rheumatic fever. They may be defined as those with both parents who have had rheumatic fever, or those who had rheumatic fever or chorea themselves in the past. Sulfadiazine in doses of one gram

Dr. Barrow is Clinical Professor of Medicine at Emory University School of Medicine, Atlanta, and Director, Georgia Regional Medical Program.

daily or oral penicillin in doses of 200,000 units twice daily have been found to be equally effective when used as daily prophylaxis. Intramuscular benzathine penicillin is more effective (99 per cent compared to 94 per cent for both oral preparations); however, it has the disadvantage of being painful, and fewer patients will continue on it faithfully over a long period time. This type of prophylaxis should be continued for at least five years after the last known attack of rheumatic fever or until the person reaches 21 years of age, whichever is longer. Any patient who already has permanent valvular damage should remain on prophylaxis for life.

It should be pointed out that daily prophylaxis with either sulfadiazine or penicillin is not a satisfactory prevention for bacterial endocarditis in those with valvular heart disease. These patients should receive full doses of penicillin or some other antibiotic before and after dental procedures, surgical procedures or maternal delivery.

938 Peachtree St., N.E.

OB-GYN SPECIALTY GROUP ANNOUNCES MANUSCRIPT AWARD

The Obstetrics and Gynecology Specialty Group of the International College of Surgeons is pleased to announce a competition for an award to be given the author of a manuscript selected by the Prize Committee of the Group. This award will consist of an invitation to present the winning paper at our meeting in Paris, France, including a round-trip ticket, hotel expenses and \$10 per diem.

The rules of the competition are as follows:

- Fellows of the International College of Surgeons are not eligible. Contestants must be interns, residents or graduate students in the field of obstetrics and/or gynecology. Contestants must hold the degree of Doctor of Medicine from an accredited college of medicine.

- Manuscripts are to represent only original work by the author without co-authorship. Manuscripts are not to exceed 5,000 words. They should be typewritten on one side of each sheet only, double-spaced and with generous margins, in English, French, German or Spanish. Illustrations, if indicated, should accompany the manuscript. Original drawings or glossy photographic prints should be numbered on the back and legends for the illustrations should be provided. A mark of identification, or the author's nom de plume, should be penciled on the back of each illustration. Tables should be numbered and submitted on separate sheets. References should be listed at the end of the article and numbered, naming the author of the reference, the pages on which the article was printed and the year of publication.

- To conceal the identity of the author, manuscripts must be *submitted under an assumed name*. The manuscript must be accompanied by a sealed envelope, containing a card bearing the assumed name of the author, the title of the manuscript and the true name of the

author, his degrees, titles and address. An original and three copies of each manuscript (carbon, photostatic, mimeographic or other) and illustrations must be submitted on or before January 15, 1970 to Doctor Eduard Eichner, Chairman of the Prize Committee, 10605 Chester Avenue, Cleveland, Ohio 44106.

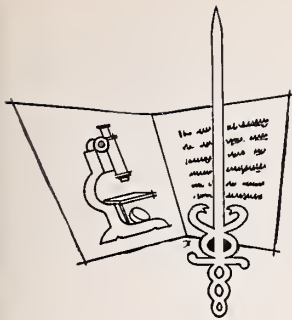
- The Committee on Prizes, under its rules and regulations, shall judge the merits of each manuscript, select the winner of the award and submit the name and address of the author to the Chairman of the Obstetrics and Gynecology Specialty Group before February 7, 1970.

- The Chairman of the Group shall notify the winning author by February 15, 1970. If no submitted manuscript is deemed acceptable by the Committee on Prizes, no award shall be made.

- The successful contestant will be asked to appear in person to participate in the regular scientific program of the Group on Obstetrics and Gynecology at the Biennial Meeting of the International College of Surgeons in Paris, France, April 20-24, 1970.

- The Secretary of the Committee on Prizes shall return the unsuccessful contributions to their respective authors. The manuscript which, in the opinion of the Committee, is entitled to the award shall become the property of the Obstetrics and Gynecology Specialty Group of the International College of Surgeons, for publication in the official *Journal of the International College of Surgeons*. If the Editors of the *Journal* reject it for publication, the author may submit it to any periodical journal of his choice.

The purpose of this contest is to advance the art and science of obstetrics and gynecology in accordance with the principles of the International College of Surgeons and with the primary aim of the College, to extend the frontiers and elevate the standards of all branches of surgery.



NON VIS SED ARTE

S. ANGIER WILLS, M.D., *Decatur*

THESE WORDS HAVE BEEN USED to caution those physicians who are called upon to entice a reluctant mother to yield her offspring. They also apply to the physician who encounters new growths in other areas of the body.

The chances for cure in many cancers are predicated on the initial diagnostic endeavors and the method of therapy chosen. Practically always the best chance of cure is with the first endeavor. The errors of omission and commission cannot be undone by future manipulations. Therefore the life history and behavioral peculiarities of various tumors must be recognized and respected.

Misapplied *Vis*

There are several types of misapplied *Vis*. One manifests itself as a mechanical ineptitude, such as in the massaging of neoplasms or the improper protection of the rest of the host from the liberations of cancer cells during surgical manipulations of tumors, something few would fail to do if they were dealing with an abscess.

Another manifests itself as a conceptual defect. The life history and behavioral characteristics of a given tumor are not considered in the diagnostic or therapeutic approach to the lesion.

But perhaps the most difficult to quell *Vis* is the evangelistic one that tempts the physician to attempt modalities of therapy that on calm objective evaluation seem to detract from, rather than enhance, palliation or perhaps the chance for survival.

There is a wide spectrum of neoplastic behavior—from slowly-growing, seldom-metastasizing tumors to fast-growing, early, prolifically-metastasizing growths. It is in the mid range of these extremes where the actions of the physician most likely influence the outcome of therapy endeavors. Pessimism is voiced by those who reflect on the latter group, while self-satisfied nihilism is voiced by those who expect to help only those patients with the former type of tumors.

Immediate Recognition

The happy outcome of treatment is predicated on the immediate recognition of the problem and knowledge of the fact that the tumor's peculiar behavioral qualities demand that it be handled in as well-planned a manner as present knowledge permits.

For instance, the lump on the jaw can be expected to recur if it is enucleated and proves to be a mixed tumor or carcinoma of the parotid gland. The physician who excises the lump in the neck and finds it to be carcinoma has greatly reduced the possibilities for cure, whereas a laryngeal mirror and a good light might have helped him proceed in a more rational manner.

A three dimensional mass in the breast that is left in place or removed without

facilities for immediate and appropriate therapy, if cancer is proven, is another excellent example of too much *Vis* and not enough *Arte*. The melanoma that is dessicated can be expected to react vigorously and malignantly toward its host and benefactor.

These are only a few of the examples of how attempts at diagnosis and cure of malignant tumors may fail if their life history and idiosyncrasies are not considered.

Awareness of Tumor Behavior

The awareness of the likely behavior and protean nature of various tumors is necessary in evaluating the efficacy of new as well as established forms of treatment. The enthusiasm for a new method may be turned to caution when one puts the observed objective response in the light of how the lesion might have behaved without treatment and especially in the perspective of whether or not harm was done in terms of morbidity, cost and inconvenience to the patient.

All these factors known, unknown and thought to be known, place a burden upon the physician to proceed along well planned lines in treating neoplasms as the special and peculiar lesions that they are, so that the patient may be afforded the best chance of cure and the lowest incidence of morbidity.

755 Columbia Dr.

LETTER TO THE EDITOR OF 'MEDICAL TRIBUNE'

(Reprinted at the request of MAG member)

Editor, Medical Tribune:

Even some physicians are talking about people's "right" to the best health care the nation can provide. Whether conceived as a collective or a government, a nation, by its very nature, is incapable of providing health care. Agents of governments, by exercise of "police power," can protect against spread of contagion and environmental hazards, but that is not health care.

"Health care" is directed to the health needs of individuals as somewhat arbitrarily distinguished from such needs as food and shelter, without which continued health is impossible. It also excludes such measures as people can adopt without expert help. It includes such measures for the diagnosis, treatment, mitigation, and prevention of disease as require the services of persons with expert skills and knowledge. . . .

Uninvited medical care is legally an assault, with or without battery, a wrongful act for which there is legal redress. Consequently, the person who will become a patient must first feel a need for which he desires the services of a practitioner. No one has a "right" to such services except as established by contract mutually agreed upon. Any other demand for services involves the "involuntary servitude" expressly forbidden by the Constitution.

"The "physician-patient relationship" is a legally binding trust agreement whereby it is explicitly or implicitly agreed that the patient places himself under the care of the physician but retains freedom to withdraw with due notice whenever dissatisfied. The physician agrees to determine whether and how the needs

can be met in ways most acceptable to the patient and to keep him so informed of what is proposed and the probable consequences that he can make informed decisions to accept or reject. He further agrees to place the patient's rights and welfare above every other consideration and to allow no outside interference with the exercise of his best clinical judgment on the patient's behalf.

Any medical care not specifically tailored to the needs of the particular patient at the time of need is worse than none, and no one other than a physician who has personally examined and questioned the patient can assess those needs or determine how they should be met. His judgment may be right or wrong but no one else has *any* valid grounds for judgment.

When the physician is employed by any person or entity other than the patient or his parent or guardian, it is that other person or entity that is practicing medicine and the physician is only the hired help. This is why the corporate practice of medicine is unlawful in most States (law more honored in breach these days than in observance). It is also why "socialized" or otherwise collective medicine deprives all except the rich of anything that can properly be called medical care. . . .

Collectivized medicine is profitable for doctors, for bureaucrats, for politicians, and attractive to all who want something for nothing; but it is unavoidably bad for patients. It is time that the "spokesmen for the medical profession" became instead spokesmen for the rights of patients and make it clear that "free choice of physician" and "freedom from third-party interference" are absolutely essential to the ethical practice of medicine.

F. B. EXNER, M.D.
Seattle, Wash.

(Reprinted with permission from the January 6, 1969, issue of "Medical Tribune.")



THE GEORGIA ANATOMICAL GIFT ACT

WILLIAM B. SPANN, JR., *Atlanta*

THE LEGISLATURE PASSED during the recent session an Act entitled the "Georgia Anatomical Gift Act." This act was signed by the Governor on March 7 and becomes effective July 1, 1969.

This act was drafted by the National Conference of Commissioners on Uniform State Laws and approved by the American Bar Association House of Delegates in August 1968, and by the American Medical Association House of Delegates in December, 1968.

With the increasing uses of human bodies and their parts in the various aspects of medical science, such as teaching, research and transplantation, such an act was a necessity and the Commissioners authorized the appointment of a Special Committee in August of 1965. The act was three years in preparation.

Competing Interests

At the outset it appeared that there were competing interests including the wishes of the deceased during his lifetime, the desires of the surviving spouse or next of kin, the interest of the State in autopsy in the case of violent death and need of autopsy to determine the cause of death when private legal rights may be dependent on such cause, and finally, the increasing need of society for bodies, tissues and organs for use in medical science. These competing interests gave rise to a great many legal questions. Who may make a legally effective gift during his lifetime? What are the rights of the next of kin either to defeat the decedent's wishes or to make gifts themselves? Who may legally receive the gifts and for what purposes may they be made? How may the gifts be made, by will, writing, etc.? How may a gift be revoked during lifetime? What are the rights and obligations of survivors after the removal of any donated parts? What protection from legal liability is afforded for surgeons and others involved? How do we resolve the conflict with the autopsy laws? How should the time of death be determined? What limitation should be placed upon the doctor determining death? These legal issues are resolved by the Uniform Act.

The Georgia Act, while not using the word "uniform" is identical with the Uniform Act except for a few style changes and the exclusion in the enumeration of those who can make a gift (Section 2(b)) of a guardian ad litem appointed for the purpose of making a gift.

Provisions of the Act

The Act is short and direct reference should be had to it to resolve any question which may arise, or an attorney should be consulted for assistance. Briefly, in

* Prepared at the request of The Medical Association of Georgia. Mr. Spann is a member of the firm of Alston, Miller & Gaines, General Counsel to The Medical Association of Georgia; he is also a member of the National Conference of Commissioners on Uniform State Laws and a member of its Executive Committee.

synopsis, the Act, after a definition section, provides that any person 18 years of age or more may give all or any part of his body to take effect on death and further permits certain surviving kin, a guardian or any other person authorized or under obligation to dispose of the body to make a gift, but only if such persons have no notice of contrary indications by the decedent or by a member of the next of kin of the same or a prior class as the classes of next of kin are set out. The Act also provides that should the donee know of the opposition by the decedent or a member of the class of next of kin, the donee shall not accept the gift. The Act then provides that donees may be hospitals, surgeons or physicians, accredited medical or dental schools, colleges or universities, a bank or storage facility set up to receive gifts. Such gifts must be for purposes of education, research, advancement of medical or dental science, therapy or transplantation. Further, any specified individual may be a donee for therapy or transplantation needed by him.

Technical Procedures

The Act then sets out the technical procedures for making a gift by will or document other than will, provides for delivery of the document or will to a specified donee or otherwise for depositing such an instrument in a hospital, storage facility or registry office which accepts it for safekeeping for facilitation of procedures after death. Various methods of revocation of the gift by the donor during his lifetime are provided, depending upon the type of instrument which has been executed to effect the gift.

The donee is permitted to accept or reject the gift and, if a part of the body only is given, the remainder of the body, after removal of the part, is returned to the surviving spouse or other person authorized to dispose of the body.

Time of Death

Most important are the provisions in Section 7 of the Act that the time of death shall be determined by a physician who attends the donor at his death or, if none, the physician who certifies death and that this physician shall not participate in the procedures for removing or transplanting a part.

Finally, it is provided that a person who acts in good faith in accordance with the terms of the Act shall not be liable for damages in any civil action or subject to prosecution in any criminal proceeding.

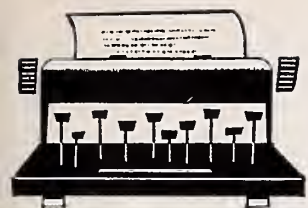
It should be emphasized that we have undertaken to set out in somewhat narrative form the background of the Act and its principal provisions, but not in sufficient detail to supplant reference to the actual Act itself in invoking any of its provisions.

Suite 1220
C & S Bank Building

FOURTH ANNUAL MURDOCK EQUEN MEMORIAL LECTURE

The Ponce de Leon Infirmary announces the fourth annual "Murdock Equen Memorial Lecture" to be held Friday, May 16 at the Regency Hyatt House in Atlanta. Richard J. Bellucci, Professor and Chairman, Department of Otolaryngology, New York Medical College, will present a paper entitled, "The Use of Split Thickness Skin Grafts in Ear Surgery."

The lecture is open to all otolaryngologists. For further information contact Charles D. Smithdeal, M.D., Atlanta, 875-7811, ext. 45.



1969—AMA Annual Convention

THE 118TH ANNUAL CONVENTION of the American Medical Association will be held July 13-17 in New York City. Approximately 22,500 physicians will be included in the nearly 60,000 registrants expected to attend the 1969 Convention. Each of the 22 scientific sections will present a program in addition to the four general scientific sessions planned for the meeting. The entire scientific program will be listed in the May 26 issue of the *Journal of the American Medical Association*.

The AMA's House of Delegates will meet at the Americana Hotel. The scientific sessions will be held in the New York Hilton Hotel and the Coliseum. Some 250 to 300 exhibits will also be housed in the Coliseum.

Of special interest to Georgians attending the 1969 AMA Convention will be the candidacy of J. Frank Walker, M.D., for Vice Speaker of the AMA House of Delegates. The Georgia Suite will be a center of interesting activity this July.

Highlights

1969 Georgia General Assembly

The 1969 session of the Georgia General Assembly, frequently criticized in the public press as a confused, do-nothing Legislature, gave to the medical profession many pieces of constructive legislation. The following is a brief summary of some of the bills of interest to the Medical Association of Georgia.

ANATOMICAL GIFT ACT: The Georgia Anatomical Gift Act will make it possible for a person to execute a legally binding Will that includes among its provisions authority for the giving of one's body (or a part thereof) for medical and dental education and research, banking and storage, and transplantation. The bill also provides that in cases where the deceased has made no declaration to the contrary, certain relatives in order of priority, may make gift of the body or a part thereof. The real essence of the Anatomical Gift Act is that a Will made pursuant to it need not be probated before becoming effective, thus avoiding the delay that in most cases would make the gift useless. MAG sponsored this bill and it has been signed into law by the Governor.

MENTAL PATIENTS' BILL OF RIGHTS: The Bill of Rights for Mental Patients attempts to revise comprehensively the laws relating to commitment, hospitalization and release of mentally ill persons. It provides for the statutory codification of the rights which must be afforded all persons voluntarily and involuntarily committed, and the legal procedures which must be adhered to by all parties involved.

The bill provides for Emergency Treatment Facilities, Evaluation Facilities, and

Hospital Treatment Facilities. It further provides for periodic court review of the necessity for continued treatment. It assures legal counsel to all those so committed throughout their entire stay.

As of this writing, the Governor has neither signed the bill, exercised his right of veto, or permitted the bill to become law without his signature. (*Signed by the Governor.—Ed.*)

VENEREAL DISEASE TREATMENT: This bill authorizes physicians to treat a minor for venereal disease without first securing consent from the minor's parents or guardian. Pursuant to this bill the physician would have the prerogative of advising the parents if he elects to do, but would not be required to consult with them. This was an MAG sponsored bill. The bill was passed by the General Assembly, but as yet has not been signed by the Governor. (*Vetoed by the Governor.—Ed.*)

FLEX EXAMINATION: Passage of the FLEX Examination bill authorized the Board of Medical Examiners to administer to prospective candidates for medical licensure an examination that has been developed by the Federation of State Examining Boards. The examination, described as one vastly more comprehensive than any ever administered before, is known as the FLEX Examination. MAG supported this bill. It passed both chambers, but as of the date this is written has not been signed by the Governor. (*Signed by the Governor.—Ed.*)

CHIROPRACTIC: There were two bills dealing with chiropractic—one in the House and one in the Senate. The House bill would have required the compulsory inclusion of chiropractic services under the Title XIX (Medicaid program). It was defeated in the House Hygiene and Sanitation Committee following lengthy hearings.

The Senate bill provided that insurance companies must cover chiropractic services in policies sold in Georgia. This bill was never acted upon in Committee and therefore remains a live bill that could be "pushed" by the chiropractors next year. MAG, of course opposed both of these bills vigorously.

JOINT BOARD OF MEDICAL AND OSTEOPATHIC EXAMINERS: A bill to create a Joint Board of Examiners for medicine and osteopathy was endorsed by MAG. The bill provided for the following main points:

- (1) That the Board of Osteopathic Examiners would cease to function after December 31, 1970, and would not issue any new licenses upon passage of the composite board bill.

- (2) That two osteopaths would be added to the Board of Medical Examiners.

- (3) That we would create two distinct classes of osteopaths: those with full practice privileges and those with restricted privileges. In the case of new applicants, passage of the examination given by the Board of Medical Examiners (FLEX) and conformity with all other requirements of the Board imposed on both medical and osteopathic graduates without distinction, would gain full practice licensure. In the case of those osteopaths presently holding an osteopathic license, the Board would issue a full practice license upon exhibiting evidence of having completed postgraduate courses to be conducted by the Medical College of Georgia and Emory University School of Medicine. Those presently licensed osteopaths who elect not to participate in these postgraduate courses would receive a limited license that prohibits the practice of obstetrics or surgery other than the minor suturing of cuts. Otherwise his practice would be

limited to the extent that he was practicing osteopathy as of the date of passage of the Composite Board bill. The existing Board of Osteopathic Examiners would retain the power to determine the nature and extent of the practice engaged in on the date of passage of the bill.

(4) That the Board of Medical Examiners be given the power to enjoin anyone for the illegal practice of medicine.

(5) That the Board of Medical Examiners would have the power to determine the good standing of medical and osteopathic schools.

This bill passed the House and was favorably reported from the Senate Health and Welfare Committee. It remains a live bill and could be called up for a vote at the 1970 session of the General Assembly.

INSTITUTIONAL LICENSES: A bill to extend the privileges of an institutional license down to the hospital authority level was reported favorably from the House Hygiene and Sanitation Committee, but never called up for a vote in the House. Under present law institutional licenses are issued only to those practitioners (aliens) who work in State institutions under the supervision of a fully licensed medical doctor. MAG will oppose this bill.

PROFESSIONAL TAX: Prior to the enactment of this bill (H.B. 87), the maximum levy for a professional licensing tax that could be imposed under Georgia law by any municipality or county was \$15. This bill, as introduced, provided for the removal of this ceiling which would have permitted local taxing authorities to impose a license tax at any level. This bill passed the House.

MAG opposed the bill vigorously in the Senate on the basis that a "sky's the limit" approach would amount to an unwarranted raid on the personal income of medical practitioners. The bill was subsequently amended to set a limit of \$200 that could be levied pursuant to this bill. The \$200 ceiling may not be imposed—but local taxing authorities are authorized to tax at this level if they elected to do so.

MAG also followed closely bills related to insurance coverage for psychiatric and psychological treatment; sterilization; transfer of mental patients from outside of the State to Georgia institutions; fluoridation; compulsory arbitration for nurses and others.

PFIZER LABORATORIES DIVISION ANNOUNCES EIGHTH ANNUAL SCHOLARSHIP PROGRAM

The Medical Department of Pfizer Laboratories Division has announced that it will make available \$1,000 medical school scholarships to each of the country's 101 medical schools, bringing to \$740,000 the total contributed since the program was launched in 1962.

Selection of the recipient of the scholarship may be on the basis of scholastic record, financial need or both. The scholarships are designed primarily to apply toward academic and subsistence expenses of one student in each of the medical schools in the United States. The scholarships are administered solely by the dean of each medical school, or by a committee established by him.

Since their inception in 1962, the Pfizer scholarships have been accepted in each of the medical schools in the United States.

In addition to the medical school scholarship program, Pfizer has also provided the American Medical Association's Educational and Research Foundation with \$480,000 in the past seven years. These Pfizer grants have provided \$6,000,000 credit for loans to medical students, interns and residents during this period. Recipients of the loans are in training in medical schools and hospitals throughout the country.

THE ASSOCIATION



NEW MEMBERS

Addison, Winnifred A., M.D. Active—Stephens—OBG	304 N. Sage Street Toccoa, Georgia 30577
Cohen, Marvyn D., M.D. Active—Muscogee—PD	1968 North Avenue Columbus, Georgia 31901
Cook, Hugh H., Jr., M.D. Active—Glynn—OBG	2400 Parkwood Drive Brunswick, Georgia 31520
Curry, Virgil L., M.D. Active—Cobb—U	2404 Austell Marietta Road Austell, Georgia 30001
Doerr, James L., M.D. Active—Troup—SU	303 Smith Street La Grange, Georgia 30240
Glucksman, Michel A., M.D. Active—Glynn—U	2400 Parkwood Drive Brunswick, Georgia 31520
Holden, David M., M.D. Active—DeKalb—PD	1275 McConnell Drive Decatur, Georgia 30033
Jelenko, Carl, III, M.D. Active—Richmond—SU	Talmadge Memorial Hospital Augusta, Georgia 30902
Lucas, Wallace, M.D. Active—Ocmulgee—GP	Peacock Street Cochran, Georgia 31014
Miles, Hollis C., M.D. Active—Baldwin—P	Central State Hospital Milledgeville, Georgia 31062
Thompson, Josiah, M.D. Active—Ogeechee River—SU	McKinley & Smith Streets Claxton, Georgia 30417
Warner, John C., Jr., M.D. Active—Cobb—PD	3001 S. Cobb Dr., S.E. Smyrna, Georgia 30080

SOCIETIES

The **Burke County Medical Society** endorsed the acquisition of a Mobile Health Unit at a March meeting with members of the local Community Action Committee, Office of Economic Opportunity, and hospital staff members. The vehicle is to make contact with people who are unaware of the services of the health center.

John Handy, M.D. spoke on "Treatment of Kidney Stones" at the March meeting of the **Richmond County Medical Society**.

Ira Slade, Jr., M.D., spoke on "Island Medicine and Polynesia" at a March meeting of the **Sixth District Medical Society**.

The **Whitfield County Medical Society** and Hamil-

ton Memorial Hospital in Dalton are holding bimonthly classes on the immediate care and transportation of the injured for local ambulance attendants.

PERSONALS

First District

Charles R. Richardson of Statesboro was installed as a Fellow of the American College of Obstetricians and Gynecologists at the annual meeting in Bal Harbour, Fla., April 28-May 1.

Frank T. Robbins of Hinesville attended the AMSCO seminar on Nursing Home and Extended Care Facility held recently in Florida. The meeting was part of a continuing education program for selected groups in the medical and para-medical profession.

Second District

The **Charles Walker** family has moved to Donaldsonville, where Dr. Walker will serve on the staff of Seminole Memorial Hospital. He was chosen in March as one of four Georgia surgeons to be installed into the American College of Surgeons in San Francisco.

Homer O. Eason of Albany has joined the partnership of **Frederick L. McLean** and **Robert T. Morgan** in Sylvester.

Fourth District

Sam Brewton has been accepted for membership on the American Board of Urology.

Ralph A. Tillman spoke on drugs and their abuse at Stone Mountain Elementary School in February.

Fifth District

William A. Hopkins spoke in March to an assembly of high school students in Rockmart.

James T. King was elected to the Council of the American Triological Society (ENT) at their annual meeting in March.

Bruce Logue lectured in March at Baylor University School of Medicine on "The Evaluation and Management of the Elderly Patient with Coronary Disease for Surgery," and in April at the East Tennessee Heart Association in Knoxville, Tenn. He spoke on "Pulmonary Embolism" and "Diagnosis and Treatment of Pericardial Disease."

Alan J. Sievert presented a film and discussion on sex education to parents only at the Josephine Wells School, Hapeville, in March.

Seventh District

Paul L. Bradley has been selected to fill the unexpired term of Trustee Frank B. McCarty on the Dalton-Whitfield County Hospital Authority.

Five Dalton physicians participated in a stop-smoking clinic in March. The topics were assigned as follows: **Earl McGhee**, "Smoking and the Nervous System"; **Lyndon Harder**, "Smoking and the Diet"; **Robert Raitz**, "Smoking and the Heart"; **Royal Farrow**, "Smoking and the Lungs," and **Robert Bowers**, "Smoking and Health—General and Summary."

Eighth District

William A. Dickson has been appointed to the State Board of Health.

Ninth District

Clarence Landers Ayers of Toccoa, 92, was honored by an article in the March 16 issue of the *Athens Banner-Herald & The Daily News*.

J. Wade Knowlton has been certified by the American Board of Surgery.

Tenth District

Ronald F. Galloway, president of the Richmond County Medical Society and vice president of the Medical Association of Georgia was the guest speaker at the annual meeting of the Augusta Area Tuberculosis Association.

DEATHS

Ovid H. Cheek

Ovid H. Cheek, Laurens County's first Commissioner of Public Health, died in a Dublin hospital March 18 at the age of 77.

Dr. Cheek was a graduate of the Atlanta School of Medicine (now Emory University) and the Chicago College of Medicine and Surgery. He served in the U.S. Army Medical Corps in World War I and was awarded the Defense Sector Medal by the Surgeons of the Army.

A past president of the Laurens County Medical Society and the Sixth District Medical Society, he was a member of the Georgia Public Health Association, the American Legion, a Mason, Shriner and a member of the Henry Memorial Presbyterian Church.

He is survived by his wife, Mrs. O. H. Cheek of Dublin; a son, Beverly B. Hayes; three granddaughters, Mrs. J. B. Penholster, Jr. of Athens, Miss Dorian Hayes and Miss Jane Hayes, both of Dublin.

Langdon C. Cheves, Jr.

Langdon C. Cheves, 56, died March 17 in a Montezuma hospital after a brief illness.

A native of Macon County, Dr. Cheves was a graduate of Berry College in Rome, Ga., and the Medical College of Georgia at Augusta. At the time of his death he was serving as first vice president of the Berry

Alumni Association and national chairman of the Association's fund campaign.

During World War II he served as a captain in the U.S. Army medical corps. He was a member of the staff at Riverside Sanatorium in Montezuma, a member of the American Medical Association and the American Association of Anesthesiologists.

Dr. Cheves was a member and deacon of the First Baptist Church in Montezuma, a Scottish Rite Mason and a member of Travelers' Rest Lodge No. 65 F. & A.M. He was a member and former president of the Montezuma Kiwanis Club. He had practiced medicine in Macon County for 24 years.

Survivors include his wife, Mrs. Sylvia Underwood Cheves, of Montezuma; two daughters, Mrs. Carey York of Montezuma and Mrs. Mike Kanazawa of Atlanta; two sisters, Mrs. Harold Guest, Sr., and Mrs. John W. Sheffield, Sr., both of Americus and one grandson, William Benson York.

Omer Seckinger Gross

Vidalia physician Omer Seckinger Gross, 64, died March 1 in Savannah Memorial Hospital after an extended illness.

The Glennville native had lived in Vidalia for 34 years. A graduate of the Struby School of Pharmacy and the Medical College of Georgia, he owned and operated the Gross-Mercer Hospital for 25 years.

Dr. Gross was a member of the First Baptist Church of Vidalia, American Medical Association, Georgia Medical Society, Director of the First National Bank, Rotary, Elks, Masons, Alee Shrine, and a former trustee of the Aidmore Hospital.

Survivors include his wife, Mrs. Willie Jones Gross, Vidalia; one son, O. S. Gross, Jr., Vidalia; two sisters, Mrs. Bonnie Bagley, Hinesville; Mrs. Bertha Smith, Glennville; two grandchildren and several nieces and nephews.

R. N. Avery

WHEREAS, Dr. R. M. Avery has been taken from us by the Grim Reaper on February 8, 1969; and

WHEREAS, Dr. Avery had served unstintingly the people of Troup County for more than 50 years; and

WHEREAS, Dr. Avery had given of his time and energy to his fellow physicians in the Troup County Medical Society in promoting and improving the practice of medicine in the area; and

WHEREAS, His death is keenly felt by his fellow associates; now

Therefore: Be it resolved, That the Troup County Medical Society wishes to extend to the widow and family of Dr. R. M. Avery their deepest sympathy and understanding of their grief at his death, and wishes to share with them the Society's collective loss of a personal friend and associate in the practice of medicine in Troup County; and

Therefore: Be it further resolved, To make this resolution a permanent part of the records of the Troup County Medical Society and spread its contents upon the minutes of said Society, and a copy of the resolution be sent to the widow and the immediate family of the deceased.

THE MONTH IN WASHINGTON

The Department of Health, Education and Welfare issued proposed regulations setting standards for rubella vaccine, making it possible it will be ready for distribution in limited quantities about June 1.

The standards cover production methods, safety, purity and potency. They were developed by the Division of Biologics Standards, a unit of the National Institutes of Health. Final regulations could be published as early as May 3. Indications were that two manufacturers would have a vaccine ready for initial distribution soon after the regulations had been made final.

"This means that we are one step closer to the prevention of a disease that has caused an untold number of tragic births," HEW Secretary Robert H. Finch said when the proposed regulations were issued.

"We are moving ahead to combat German measles in the quickest manner consistent with public safety."

Apply to HPV-77

The regulations apply to vaccines containing a live virus strain known as HPV-77, which is grown in either duck embryo or dog kidney cell culture systems. Experimental vaccines produced in accordance with the standards have undergone extensive community testing in the United States and abroad. Two manufacturers, Merck, Sharp & Dohme and Philips Roxane Laboratories have produced vaccines based on this strain.

"We hope that more than one vaccine will be available," Dr. Robert Q. Marston, NIH Director, said. "Regulations covering the use of other virus strains and culture media for rubella vaccine production will be formulated on the basis of extensive tests now going on."

Smith, Kline & French Laboratories has tested widely an experimental vaccine containing the Cendehill strain of rubella virus.

An HEW announcement said: "German measles is a threat to susceptible pregnant women at any time, but the threat increases significantly during epidemic years. One of the most tragic and disastrous epidemics to hit the United States in modern times was the German measles epidemic of 1964-1965. This resulted in about 50,000 abnormal pregnancies. About 20,000 infants were born with such crippling defects as mental retardation, heart disease, blindness and deafness. The remaining 30,000 pregnancies terminated in miscarriage or stillbirth."

Antibiotic Combinations

The Food and Drug Administration has taken the first step to halt the marketing of 78 antibiotic combination products.

The ultimate action was recommended by the National Academy of Sciences-National Research Council, which is evaluating the effectiveness of about 3,600 new drugs marketed from 1938 to 1962. Generally,

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tients are accepted and departmentalized care is provided according to sex and the degree of illness.

In addition to the psychiatric staff, consultants are available in all medical specialties.



MEDICAL DIRECTOR:
James A. Becton, M.D.

CLINICAL DIRECTORS:
James K. Ward, M.D.
Hardin M. Ritchey, M.D.

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AMERICAN HOSPITAL ASSOCIATION . . .
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the 78 products were found ineffective as fixed combinations for claims made in their labeling. The FDA emphasized that this does not necessarily mean that either the antibiotics or other active ingredients of the products are ineffective when used alone.

"But the use of two or more active ingredients in the treatment of a patient who can be cured by one is irrational therapy," said Herbert L. Ley, Jr., M.D., Commissioner of Food and Drugs. "It exposes the patient to an unnecessary risk. Antibiotics should be used like a rifle rather than a shotgun."

Drugs Affected

The majority of the 78 products are antibiotic-sulfa combinations in tablet, capsule, or liquid form. Also included are 16 penicillin-streptomycin combinations that are given by injection.

Other antibiotics used in the preparations include erythromycin, neomycin, tetracycline, chlortetracycline, nystatin, oxytetracycline, oleandomycin, and triacetyleandomycin. In addition, some of the preparations contain analgesics, vitamins, or other ingredients.

The antibiotics combinations are the products of 21 different manufacturers, including Chas. Pfizer & Co.; Eli Lilly & Co.; Lederle Laboratories division of American Cyanamid Co.; Bristol Laboratories Inc., a division of Bristol-Myers Co.; Merck & Co.; E. R. Squibb & Sons Inc., a subsidiary of Squibb Beech-Nut Inc.; Upjohn Co.; Wyeth Laboratories Inc., a subsidiary of American Home Products Corp.; Abbott Laboratories; and Hoffmann-La Roche Inc. In an earlier proposal last December, the FDA similarly moved against products marketed by Squibb, Lederle and Upjohn.

Widely Accepted Products

Many of the affected products have been promoted widely and found wide acceptance in the medical profession. Several of the manufacturers promptly said they would contest the FDA ruling and others were expected to oppose it also. The manufacturers were given 30 days to submit any new data on efficacy of the products.

There were 12 products in the first groups, announced last December. A decision still was pending on whether manufacturers of those products should have additional time to submit evidence of efficacy.

The FDA can halt the marketing of antibiotic-containing preparations by deleting them from regulations listing the antibiotic drugs acceptable for certification. Antibiotics and insulin, unlike other drugs, must be certified on a batch-by-batch basis before they can be marketed.

Medical Journal Advertising

Two spokesmen for the medical profession asserted before a Senate subcommittee that the policies and scientific journals of their organizations are not biased in favor of the prescription drug industry because of the drug advertising revenue.

Senator Gaylord Nelson (D., Wis.), chairman of the Senate Monopoly Subcommittee which is making a broad study of the ethical drug industry, accused the medical journals of following the pharmaceutical industry's line to get advertising dollars. Both Dr. Edward R. Annis, a member of the AMA Board of Trustees, and Dr. Maynard I. Shapiro, president of the AAGP, emphatically denied the charge. Both cited

the high, objective advertising standards of their organizations' publications.

AMA Rebuttal

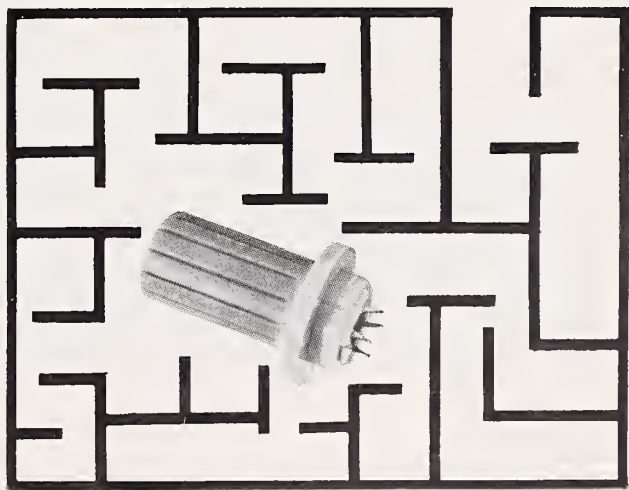
"The American Medical Association's programs and policies have never been, are not now, and will never be shaped by any dependence on the drug industry," Dr. Annis said. "And to assure that there is no conflict of interest, the AMA has consistently separated the editorial management, advertising acceptance, and business management of each of its scientific publications. . . ."

"We believe that no publication surpasses our own standards for acceptable advertising."

Nelson sharply criticized the *Journal of the American Medical Association* as to the ads it carried on chloromycetin after the drug had been judged to be extremely dangerous. Annis acknowledged that "one Madison Avenue effort . . . slipped through the net" of AMA advertising standards. But he pointed out the various warnings on the drug carried in the editorial content of *JAMA* and other AMA publications.

AAGP Policy

"Advertising is screened by a group of physicians, all of whom we consider qualified to perform their task," Dr. Shapiro said. "We don't list the names of these physicians in our magazines because we believe they prefer a degree of anonymity. All are medical school faculty members and all, in our opinion, are well qualified to screen pharmaceutical advertising."




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WASHINGTON / Continued

Dr. Shapiro also said that at least two drug firms had canceled ads in AAGP publications after they had carried editorials adverse to the companies.

Hill-Burton Block Grants

The Nixon Administration recommended to Congress that the Hill-Burton hospital construction and improvement program be changed to permit block allocation of grant funds to States. Since enactment of the first Hill-Burton legislation in 1946, Federal grants for it have been earmarked for specific purposes.

In a statement to the House Health Subcommittee, Robert H. Finch, secretary of Health, Education and Welfare, said the nation's health needs had changed since the Hill-Burton program was started. Today's needs, he said, are twofold:

—Modernization or replacement of existing and obsolete acute care facilities in the hospitals and

—Expansion of other kinds of medical facilities to reduce the pressures on hospitals and help curb skyrocketing medical costs.

He recommended a \$150 million annual grant authorization for construction, replacement or modernization of the most critical types of health facilities.

Balance Health-Care Facilities

"Additionally, we recommend the removal of the existing Hill-Burton categories to provide a better balance of health-care facilities in the community by assisting those kinds of facilities which have traditionally been neglected or are in short supply," he said.

Expansion of neighborhood health center programs also was recommended. The HEW statement said it

was required to meet the health needs of the poor.

H. Phillip Hampton, M.D., Tampa, Fla., testifying for the AMA, said the AMA continues its long-standing support of the Hill-Burton program but believes that "the major need that exists today is for the improvement and effective use of existing facilities."

The AMA supported a provision in one of the two Hill-Burton bills before the subcommittee that would permit States to transfer funds from one allocation to another, providing "further elasticity to the transfer of funds from construction to modernization."

Priorities Unnecessary

The AMA opposed as unnecessary the establishment of Hill-Burton priorities for construction or modernization of out-patient facilities or facilities to provide comprehensive health care. Such needs should be met through other laws already enacted, the AMA said. Dr. Hampton explained:

"We hope to make this point clear: We understand the part played by hospital outpatient departments in providing a place for necessary services to a community, and to the role played in teaching and training. But we believe that any need for outpatient facilities, separate and apart from the hospital, or for free-standing diagnostic and treatment centers—or whatever they may be called—can be met through other programs which provide Federal assistance. The Hill-Burton program is not the appropriate vehicle for grants or priorities for such separated facilities. Nothing has been demonstrated which indicates either public benefit or public acceptance for this concept of providing ambulatory medical care through hospital-operated, rather than physician-operated, neighborhood clinics."

INSPECTION OF PHYSICIAN OFFICE LABORATORIES

JOHN T. GODWIN, M.D.

Pathologist, St. Joseph's Infirmary, Atlanta

It is evident that there is little information concerning performance evaluation in the private physician's laboratory. At the present time there are no regulations or requirements concerning quality control, proficiency testing or personnel.

In view of the fact that independent and hospital laboratories are being regulated and inspected for accreditation and to meet Medicare requirements, it would appear that it is only a matter of time until laboratories of private physicians will be under scrutiny.

In order for the private physician to be assured of quality performance in his laboratory, he should determine the qualifications of his technologists, the quality of instruments used, the proper maintenance and calibration of equipment, the procedures employed, the use of quality control sera, standard deviation of various tests, accurate record keeping and various other factors. It is possible that the physician may require the assistance of a pathologist to evaluate his laboratory and performance unless he has had experience in these areas.

Private physicians should begin now to determine the status of their laboratories and personnel before, and in anticipation of, required inspection and regulation.

Your local or consulting pathologist should be helpful to you in solving this problem.

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CALENDAR OF MEETINGS

In Georgia

- May 18-21—Annual Meeting of the Georgia Public Health Association, DeSoto Hilton Hotel, Savannah.
- May 22-23—"Immune Responses—Helpful and Harmful," Jekyll Island (Postgraduate course sponsored by the Medical College of Georgia).
- June 27-July 3—Annual Meeting of the American Society of Radiologic Technologists, Regency-Hyatt House, Atlanta.

In the Nation

- May 21-23—Mid-South Medical Assembly, Rivermont-Holiday Inn, Memphis, Tenn.
- May 24-26—National Tuberculosis and Respiratory Disease Association, Fontainebleau Hotel, Miami Beach, Fla.
- May 24-26—American Thoracic Society, Fontainebleau Hotel, Miami Beach, Fla.
- May 26-28—American Ophthalmological Society, The Homestead, Hot Springs, Va.
- May 29-June 1—Congress on Medical and Related Aspects of Motor Vehicle Accidents, Americana Hotel, New York, N.Y.
- June 2—International Conference on Drug Abuse, Americana Hotel, New York, N.Y.
- June 9-13—Artificial Heart Conference (Sponsored by the National Institutes of Health), The Shoreham Hotel, Washington, D.C.
- June 16-19—American Proctologic Society, Statler-Hilton Hotel, Boston, Mass.
- June 18-22—American Rheumatism Association, Statler-Hilton Hotel, Boston, Mass.
- June 19-21—American Medical Women's Association, Alta Mira Hotel, Sausalito, Calif.
- June 23-26—American Orthopaedic Association, The Homestead, Hot Springs, Va.

GRADUATE MEDICAL ASSEMBLY WAS UNQUALIFIED SUCCESS

The 1969 Atlanta Graduate Medical Assembly, under the leadership of F. William Dowda, M.D., was convened February 24-26 at the Regency Hyatt House. The 1969 meeting was one of the most successful in the history of the Assembly. A total of 1,349 physicians attended the meeting; the over-all attendance was 1,985.

The 1969 Assembly featured an outstanding faculty of 22, each a well-known authority in his specialty.

Monday's program featured concurrent sessions in surgery and cardiology; Tuesday featured full-day sessions in cancer and medicine; Wednesday's format included a second full day of medicine and a full day of obstetrics and gynecology.

The 27th annual session of the Atlanta Graduate Medical Assembly will be held March 8, 9, 10, 1970, at the Atlanta Marriott Motor Hotel with J. Gordon Barrow, M.D. serving as Chairman.

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HIGHLIGHTS OF EXECUTIVE COMMITTEE OF COUNCIL CONFERENCE CALL MEETING, APRIL 11, 1969

This summary is being published so that MAG members may be advised of the actions of the Executive Committee between meetings of Council. It covers only major actions and is not intended as a detailed report in lieu of meeting minutes.

Suggested change in minutes of February 23, 1969 meeting regarding Georgia State Nursing Association activities—At the request of Fourth District Council, Dr. Floyd Sanders, the Executive Committee voted to correct the minutes of its February 23 meeting to read that Dr. Sanders "expressed the feeling of the DeKalb County Medical Society and the DeKalb Hospital Authority about the statement issued by MAG."

State Board of Health appointments—Executive Committee heard a report of the names of nominees

received from the First District and the Fifth District for appointment to the State Board of Health. First District nominees are: Louie Griffin, M.D., Claxton; J. C. Metts, Jr., M.D., Savannah; and Louis R. Jelks, M.D., Reidsville. Fifth District nominees are: Lamar Peacock, M.D., Atlanta; William W. Moore, M.D., Atlanta; and Linton H. Bishop, M.D., Atlanta. These nominations will be presented to the Council, and then sent to the Governor.

Suit to enjoin the Director of the Department of Public Health—Following a report by the MAG Legal Counsel, Mr. John Moore, the Executive Committee voted to authorize the attorneys to request a dismissal of the appeal of the trial court's decision on MAG's suit, and to seek an agreement with attorneys for the Georgia Osteopathic Medical Association that no further litigation be pursued at this time.

90 Years Ago

A Case of Placenta Praevia

BY A. A. SMITH, M.D., HAWKINSVILLE

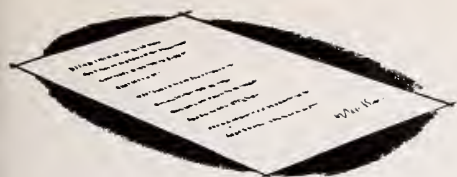
On the morning of the 23d of February last I was called to see Mrs. B., with Dr. A. R. Taylor. On arriving, we found that at four o'clock that morning she had had a profuse hemorrhage, and at that time there was a gradual oozing going on. This we learned was the third attack, she having had one ten and another three days previous, and each attack being unattended by pain. The patient was believed to be in her seventh month of pregnancy. This was her third confinement, and the only one in which there had been any abnormal or untoward symptoms. She had enjoyed good health until the first attack, which came on without assignable cause. We at once made an examination, per vaginam, and found the os sufficiently dilated to admit one finger, the os internum was completely occupied by the placental mass, the attachments were firm and unyielding, except at the left lateral side, where there was a partial separation of the adhesions, which was the immediate cause of the hemorrhage.

It was now evident that the case was one of placenta praevia, and that no time should be lost in effecting a delivery. The head and shoulders were lowered, and an opiate, combined with a full dose of fluid extract of ergot (Squibbs) was administered. The treatment which we pursued then was to dilate the os fully, which was done by introducing a Barnes' bag or di-

lator and using a Davidson's syringe to pump the water into it. A stimulant was then given, and the patient allowed to rest one hour, when the dilator was removed and the os found to be dilated sufficiently to admit two fingers. The adhesions were then severed by making a sweep around as far as could be reached by the fingers. This was followed by a profuse flow of blood, which, however, did not continue, as the membranes were ruptured immediately, and at the same time a pain coming on, the head came down, which served as a plug or compress on the bleeding vessels, thus converting the placental complication into a case of natural labor, with a vertex presentation and second position. Ergot and stimulants were given freely, the pains came on regularly and at four o'clock, five hours after first seen, the patient was delivered of a seven months child which had been dead several hours. With the expulsion of the child, the placenta was also expelled and lodged in the vagina. The uterus was firmly compressed and well contracted, the flow of blood was no greater than in ordinary cases of natural labor. Patient convalesced rapidly and is now well.

A careful examination of the placenta showed it to be of natural size and normal, except that instead of the cord being attached in its usual place it was situated about one and one-half inches from the left marginal surface, near where the portion of placenta was first detached. There can be no cause assigned for the death of the foetus, except the loss of blood which preceded its birth.

From Transactions of the Medical Association of Georgia, Thirtieth Annual Session, Rome, April 16-18, 1879.



ABSTRACTS BY GEORGIA AUTHORS

Choithani, C. M., M.B., F.R.C.S.E., Evans, George H., M.D., and Scardino, Peter L., M.D., Dept. of Urology, Memorial Medical Center, Savannah, Ga., "Nosocomial Ureteral Injuries," *Southern Med. J.* 61:1180-1186(Nov.)1968.

The most common culprit in hospital acquired ureteral injury is the surgeon's knife. Ureteral injuries may follow abdominal, pelvic or gynecological surgery; transurethral resection of the prostate gland, bladder tumor or endoscopic extraction of ureteral stones; vascular surgery, bowel resection for cancer and various neurosurgical operations.

Eight cases have been selected from a 14-year experience to illustrate the most common complications of hospital acquired ureteral injury, methods of management and follow-up investigation.

While the only necessary procedure required may consist of periodic ureteral catheterization, ureteral exploration, lysis, suture removal, splinting, nephrostomy may be the renal-saving procedure, but nephrectomy a last resort. With mobilization of the ureter and/or kidney, two inches of additional length of ureter may be obtained to permit end-to-end ureteroureterostomy or uretero-neo-cystostomy. Bladder flap substitute (Boari), bowel substitutes, trans-ureteroureterostomy, uretero-neo-cystostomy, are procedures which have been successfully used.

Lowance, Mason I., M.D., Lowance Clinic, Atlanta "Emulsified Extract: 1967 Report," *Southern Med. J.* 61:990-992(Sept.)1968.

It is impossible to dissociate the immediate, or even the remote implications of allergy from daily clinical practice, whether the physician be general practitioner or specialist. The mo-

ment of truth which acknowledges the indissoluble relationship between general medicine and allergy represents part of the background of the Allergy Committee for the Study of Repository Therapy, Inc., founded in 1965.

ACSORT has sought and seeks dialogue with positive results, to bring about intensive, cooperative research in allergy, particularly in the preparation of allergenic extracts. ACSORT has endeavored to secure Federal approval of a standardized vehicle for preparation of emulsified extracts. While awaiting approval, allergists are preparing their own vehicles. Although personal professional preference among ACSORT members, based on clinical experience and confirmed by statistics, is toward continued use of emulsified extracts, results with other modalities are not disregarded.

Allergists administering emulsified extracts believe that by not having to be concerned with time-consuming regimens of injections, the doctor is free to devote full attention and efforts toward psychologic evaluation and management of physical symptoms.

Perdue, Garland D., Jr., and Smith, Robert B., III, M.D., Joseph B. Whitehead Dept. of Surgery, Emory U. School of Med., Atlanta, "Diagnosis and Treatment of Renovascular Hypertension," *Southern Med. J.* 61:732-735(July)1968.

On the basis of aortographic demonstration of renal artery stenosis and evidence of impaired renal function as determined by the "urea-washout" pyelogram, isotope renogram, and differential excretion test, 41 patients were diagnosed as having renovascular hypertension from 1962 through 1966. Operation to correct ischemia resulted in remission of hypertension to normotensive levels in 22 and marked improvement in ten. There were no op-

erative deaths, but three patients died during the first post-operative year, all of cardiovascular diseases. The blood pressure was not improved in the remaining six patients.

Increasing use of bio-assay of renin activity in blood from the renal vein or suprarenal vena cava should lead to further improvement in the selection of cases. With careful case selection and assurance of technical success, a large percentage of patients operated on can expect benefit from surgery.

Kite, J. H., M.D., 490 Peachtree Street, N.E., Atlanta, "Congenital Pseudarthrosis of the Clavicle," *Southern Med. J.* 61:703-710(July) 1968.

Congenital pseudarthrosis of the clavicle is a very rare finding, and only 21 cases have been reported in the literature. Few orthopedic surgeons have had experience with this condition for this reason. The reported cases are reviewed and eight more added.

Study of these eight cases made it necessary to divide them into two distinct classifications, which has not been done previously. Six were Type I, in which the clavicle developed from two segments and failed to unite in the middle. This is the type which has been reported previously. It may be noticed at birth or shortly after. It is a congenital deformity and has been confused with cleido-cranial-dysostosis. An odd finding is that 23 of 27 cases reported occurred on the right side. Some surgeons have operated upon all of their cases. It presents no functional disability, and the operation is done chiefly for cosmetic reasons.

In Type II form there is an osseous deficiency in the clavicle similar to that occurring in congenital pseudarthrosis of the tibia. Two cases presented this condition, one of which was successfully bone grafted.

DR. FINCHER RECEIVES POSTHUMOUS AWARD

Atlanta's Dr. Edgar Franklin Fincher received the Award of Honor posthumously from Emory University's Medical Alumni Association Saturday, February 22. A former Emory professor of neurological surgery, Dr. Fincher died in January at the age of 68. The award was given to his widow during Medical Alumni Day activities on the Emory campus.

Dr. Fincher graduated from Boys High School in Atlanta and received his B.S. and M.D. degrees at Emory in the 1920s. He had practiced brain surgery in Atlanta since 1930 and was a member of the staff of eight Atlanta hospitals.

The son of a doctor and a native of Stone Mountain, he served as a major in the U.S. Army medical corps in World War II. He was a founding member of the American Board of Neurological Surgery and of the Southern Neurological Society. He was a former president of the Harvard Cushing Society, a fellow in neurological surgery at Washington University, St. Louis, Mo., and at the Mayo Clinic, Rochester, Minn.

Making the presentation to Mrs. Fincher was Dr. Charles R. Underwood of Marietta, president of the Emory Medical Alumni Association.

MEDICAL SCHOOL STUDIES CANCER FAMILY SYNDROME

The Medical Genetics Section of the Department of Preventive Medicine and Public Health at Creighton University School of Medicine, Omaha, Nebraska, is interested in the study of patients showing an increased incidence of any histological variety of cancer in their families. Of particular interest is the cancer family syndrome, characterized by: (1) increased frequency of adenocarcinoma of all sites, particularly of the colon and endometrium; (2) early age at onset of cancer; (3) increased occurrences of multiple primary malignant neoplasms; and (4) autosomal dominant inheritance. To date, we have investigated six families fulfilling all of the above criteria (Lynch, H. T., and Krush, A. J.: Heredity and Adenocarcinoma of the Colon, *Gastroenterology* 53:517-527, 1967),

and have corresponded with physicians in Europe who have described two separate and non-related families which also fulfill the above criteria.

Physicians with patients known to have a familial cancer background, may write to Henry T. Lynch, M.D., Associate Professor and Chairman, Department of Preventive Medicine and Public Health, Creighton University School of Medicine, 657 North 27th Street, Omaha, Nebraska 68131.

We invite your cooperation in our studies which will include a genealogical and medical investigation of the entire kindred in each case. All information obtained will be shared with family physicians in order to facilitate cancer control.

MAG YEARBOOK WILL REPLACE ROSTER

This year for the first time the MAG Staff will produce an MAG Yearbook, an idea approved by the Executive Committee of Council in October 1968. The Yearbook will replace the Roster which has appeared in January of each year, and will be prepared in late summer following the annual meeting and appointment of MAG Committees.

The Yearbook will include alphabetical and geo-

graphic membership lists, officers, councilors, and committees of MAG, county medical society officers, district medical society officers, specialty medical society officers, Georgia hospitals, and a complete MAG Constitution and Bylaws. Coming soon after the annual meeting, information in the Yearbook will be accurate and will serve as a valuable reference for every member.

*"Either we shall master the ways
of Political Action, or we shall be
mastered by those who do."*

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MAG General Session (First Session)

115th Annual Session of the Medical Association of Georgia

Sunday, May 4, 1969

THE FIRST GENERAL SESSION of the 115th Annual Session of the Medical Association of Georgia was called to order by President Charles R. Andrews, Jr., Canton, at 1:00 p.m. in the Ballroom, Savannah Inn and Country Club, Savannah, Georgia, on May 4, 1969.

Dr. Andrews welcomed those members present, and stated that it was most appropriate on this Lord's day to count our blessings and give thanks together. Dr. Andrews called on the Rev. Warren Hayes, Rector of Christ Episcopal Church, Savannah, to lead the General Session in the Invocation.

Dr. Andrews then presided as the color guard presented the colors, and the national anthem was sung.

In further reverence of the Sabbath Day, Dr. Andrews introduced the Rev. Paul B. McCleave of Chicago, Director of the AMA Department of Medicine and Religion, who brought some thoughts to the group present.

Greetings

President Andrews then recognized the President of the Georgia Medical Society, Dr. John G. Zirkle of Savannah, who extended words of welcome to the Association from the host society.

President Andrews then recognized the Honorable J. Curtis Lewis, Jr., Mayor of Savannah, and asked MAG Past President, Dr. Walter Brown of Savannah to escort Mayor Lewis to the podium. Mayor Lewis brought the greetings of the City of Savannah to the Association and presented President Andrews with a symbolic key to the city.

President Andrews then recognized Dr. Irving Victor, who introduced Mr. Reed Williamson, Executive Director of Savannah Restoration, Inc., who presented an interesting slide presentation on the "Exciting Story of Savannah's Restoration."

President Andrews then stated that the order of business this afternoon concerned the nominations of MAG officers, councilors and vice-councilors, MAG delegates and alternate delegates to the American Medical Association, and finally to record nominations for MAG "General Practitioner of the Year Award."

Tellers Committee

Before proceeding with the business, President Andrews announced the appointment of the Tellers Committee to take charge of the official MAG ballot box as follows: John T. Mauldin, Atlanta, Chair-



The Honorable J. Curtis Lewis, mayor of Savannah, presents the key to the city to MAG President Charles R. Andrews.

man; George H. Alexander, Forsyth; and Walter E. Brown, Savannah.

President Andrews then announced the location of the ballot box and stated that the hours for voting as set by the MAG Council were to be at the close of that session, May 4, from 2:30 p.m. to 5:00 p.m.; May 5, from 8:00 a.m. to 6:00 p.m.; and May 6, from 8:00 a.m. to 6:00 p.m., at which time the ballot box would close so that the election results could be tabulated and announced at the Wednesday, May 7, final session.

Nominations

President Andrews then called for nominations from the floor for the Association's Officers and the following nominations were made:

President-Elect—F. G. Eldridge, Valdosta, nominated by Charles Andrews; seconded by J. Frank Walker, Roy Gibson, and Hoke Wammock.

There being no other nominations for the office of President-Elect, on motion duly made and seconded, the nominations were closed and President Andrews instructed the Secretary to cast the unanimous ballot for F. G. Eldridge as President-Elect of the Medical Association of Georgia.

Second Vice President—F. William Dowda, Atlanta, nominated by William Osborne; seconded by Charles Cowart, Joseph Wilson, J. Kirk Train, and Walter Brown.

There being no other nominations for the office of Second Vice-President, on motion duly made and seconded, the nominations were closed and President Andrews instructed the Secretary to cast the unanimous ballot for F. William Dowda as Second Vice-President of the Medical Association of Georgia.

Secretary—John Rhodes Haverty, Atlanta, nominated by J. Frank Walker; seconded by John Kirk Train, and John T. Godwin.

There being no other nominations for the office of Secretary, on motion duly made and seconded, the nominations were closed and President Andrews instructed the Secretary to cast the unanimous ballot for John Rhodes Haverty as Secretary of the Medical Association of Georgia.

President Andrews noted that according to MAG Bylaws as revised in 1966, under Chapter 5 Section 2 Nominations, it stated that if a district society or a component county medical society is entitled to direct representation by one or more councilors and vice-councilors, the Secretary of the MAG must receive no later than 15 days before the Annual Session written notice of the election of councilors and vice-councilors, that these councilors and vice-councilors may be considered by the Association as duly elected, and nominations from the floor are only to be accepted in the absence of such notification of election to the Secretary of MAG 15 days in advance of an annual session. President Andrews stated that he was happy to report that the districts and county medical societies whose councilors' and vice-councilors' terms of office had expired had duly notified MAG of their election and that no nominations from the floor were then in order. Dr. Andrews then read the notification of these elections as received by MAG from the Secretary of the respective district and county medical societies as follows:

Ninth District Councilor—Paul T. Scoggins, Commerce—1969-72

Ninth District Vice-Councilor—Robert S. Tether, Gainesville—1969-72

Tenth District Councilor—Edwin W. Allen, Jr., Milledgeville—1969-72

Tenth District Vice-Councilor—Marion A. Hubert, Athens—1969-72

Bibb County Medical Society Councilor—Braswell E. Collins, Macon—1969-72

Bibb County Medical Society Vice-Councilor—Milton I. Johnson, Macon—1969-72

Cobb County Medical Society Councilor—W. C. Mitchell, Smyrna—1969-72

Cobb County Medical Society Vice-Councilor—Reimer Y. Clark, Marietta—1969-72

DeKalb County Medical Society Councilor—Floyd R. Sanders, Decatur—1969-72

DeKalb County Medical Society Vice-Councilor—M. Freeman Simmons, Decatur—1969-72

Fulton County Medical Society Councilor—Fleming L. Jolley, Atlanta—1969-72

Fulton County Medical Society Vice-Councilor—Thomas J. Anderson, Atlanta—1969-72

Richmond County Medical Society Councilor—Joseph L. Mulherin, Augusta—1969-72

Richmond County Medical Society Vice-Councilor—Daniel B. Sullivan, Augusta—1969-72

President Andrews then stated that MAG had been notified by the president of the Second District that their Vice-Councilor, R. A. Malone, had resigned. In his place the Second District elected Donald R. McKenzie to serve out the term of Second District Vice-Councilor until 1970.

AMA Delegates and Alternate Delegates

President Andrews called for nominations for MAG Delegates to the American Medical Association and stated that he would identify the elective posts by announcing the name of the incumbent in office and also by giving the term of office.

AMA Delegate (for the office held by J. W. Chambers, of LaGrange; the term beginning January 1, 1970 and expiring December 31, 1971)—J. W. Chambers, LaGrange, nominated by Charles Cowart; seconded by George Alexander.

There being no further nominations, on motion duly made and seconded, it was voted to close the nominations and President Andrews instructed the Secretary to cast a unanimous ballot for the election of J. W. Chambers.

AMA Alternate Delegate (for the office held by Neal F. Yeomans, of Waycross; the term beginning January 1, 1970, and expiring December 31, 1971)—Neal F. Yeomans, Waycross, nominated by Donald R. Rooney; seconded by Hoke Wammock.

There being no further nominations, on motion duly made and seconded, it was voted to close the nominations, and President Andrews instructed the Secretary to cast a unanimous ballot for the election of Neal F. Yeomans.

AMA Delegate (for the office held by John S. Atwater, Atlanta; the term beginning January 1, 1970, and expiring December 31, 1971)—John S. Atwater, Atlanta, nominated by Linton Bishop; seconded by Walter Brown.

There being no further nominations, on motion duly made and seconded, it was voted to close the nominations, and President Andrews instructed the Secretary to cast a unanimous ballot for the election of John S. Atwater.

AMA Alternate Delegate (for the office held by Henry S. Jennings, Gainesville; the term beginning January 1, 1970, and expiring December 31, 1971)—Henry S. Jennings, Gainesville, nominated by Robert Tether; seconded by Fleming L. Jolley.

There being no further nominations, on motion duly made and seconded, it was voted to close the nominations, and President Andrews instructed the Secretary to cast a unanimous ballot for the election of Henry S. Jennings.

GP of the Year Award

President Andrews then stated that he wished to recognize those nominations for the Medical Association of Georgia award for the General Practitioner of the Year. He stated that these nominations had been officially received at least two weeks in advance and that they were so declared as official nominations. Dr. Andrews then announced the official nominees as follows:

Dr. Reuben S. O'Neal, of LaGrange, nominated by the Troup County Medical Society; Dr. William Alfred Mendenhall, of Chamblee, nominated by the Georgia Academy of General Practice, and Dr. Abraham Germain, of Atlanta, nominated by the Georgia Academy of General Practice.

Dr. Andrews stated that the GP of the Year Award nominations, having been received and duly recorded, would be presented to the MAG House of Delegates at its meeting in the Ballroom, Savannah Inn and Country Club, on Monday, May 5, at which time the House itself would vote and elect the General Practitioner of the Year Award recipient.

There being no further business, President Andrews then recessed the First General Session of the 115th Annual Session of the Medical Association of Georgia at 2:30 p.m.



Lee Howard, Jr., M.D., the local arrangements chairman; John G. Zirkle, M.D., president of the Georgia Medical Society, and Preston D. Ellington, M.D., the Annual Session chairman.

MAG General Session (Second Session)

115th Annual Session of the Medical Association of Georgia

Monday, May 5, 1969

THE SECOND GENERAL SESSION of the 115th Annual Session of the Medical Association of Georgia was called to order by President Charles R. Andrews, Jr., of Canton, at 9:00 a.m., in the Ballroom, Savannah Inn and Country Club, Savannah, on May 5, 1969.

President Andrews called on Dr. Rupert Bramblett, of Cumming, to open the meeting with a prayer.

President-Elect's Address

President Andrews then called on President-Elect John Kirk Train, Savannah, who presented his Incoming President's Address to the Association membership on "Medical Progress and the Challenge to MAG."

Auxiliary Report

President Andrews then called on W. C. Mitchell, Smyrna, to escort Mrs. S. William Clark, Jr., of Waycross, President-Elect of the Woman's Auxiliary to the Medical Association of Georgia, to the stand where she delivered the report of the MAG Auxiliary in behalf of Mrs. Hayward Phillips, Augusta, President of the MAG Auxiliary.

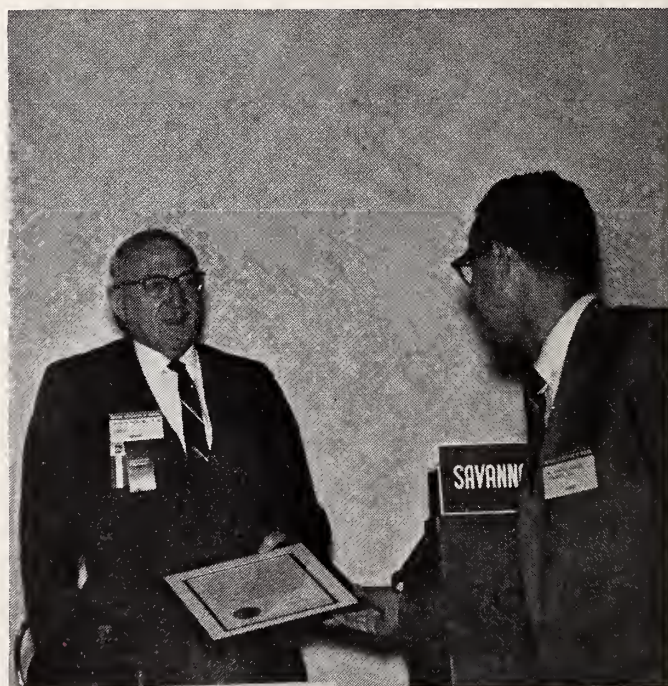
SAMA

President Andrews then announced that two special guests would be extended the privilege of the floor for brief remarks to the Association. Dr. Andrews explained that there had been a recent rebirth of activity in the two Student-AMA chapters in Georgia, and that the presidents of those two chapters would be invited to address the Association. Dr. Andrews introduced first Mr. John R. Cone, president of the SAMA chapter at Emory University, who delivered a message to the Association. Dr. Andrews then recognized Mr. Ron F. Digby, presi-

dent of the SAMA chapter at the Medical College of Georgia, who also spoke to the Association.

President Andrews then recognized Mr. Dan Barker, Immediate Past President of the Georgia Hospital Association, who presented the Association with a framed copy of a resolution adopted by the Georgia Hospital Association recognizing MAG and expressing its appreciation to MAG for the cooperative attitude being displayed between these two organizations.

At this point, President Andrews announced that the Second MAG General Session would be recessed, and that the meeting would be turned over to Dr. Harrison L. Rogers, Atlanta, Speaker of the House of Delegates, to preside at the First Session of the MAG House of Delegates meeting.



MAG President Andrews accepts the Georgia Hospital Association Resolution Presentation from Mr. W. Dan Barker.

First Session, House of Delegates

Monday, May 5, 1969

THE FIRST SESSION of the House of Delegates of the Medical Association of Georgia was called to order by Speaker Harrison L. Rogers, Jr., Atlanta, at 9:45 a.m., in the Ballroom, Savannah Inn and Country Club, Savannah, Georgia, in conjunction with the 115th Annual Session of the Medical Association of Georgia.

Speaker Rogers called for a report of the delegates' attendance. Dr. Irving D. Hellenga, Toccoa, Vice-Chairman of the House of Delegates Credentials Committee, reported that there were 132 delegates present and registered, representing 50 component societies, and that there was a quorum of more than 40 members present and accounted for. A complete report made by the Credentials Committee on the attendance at the First Session of the House of Delegates follows:

Attendance

In a compilation of attendance taken from the official roll, 50 county medical societies were presented by their duly elected delegates or alternates. Of a total of 165 authorized delegates by their respective medical societies, the official roll showed 132 delegates present at this First Session.

BALDWIN: W. M. Headley; W. T. Smith; BEN HILL-IRWIN: H. L. Dismuke; BIBB: W. A. Bootle; Charles G. Burton; Reece Eberhardt; F. V. Kay; Charles A. Lanford; Hugh F. Smisson; Henry Tift; OGEECHEE RIVER: Robert S. Robinson; BURKE: E. R. Hensley; CARROLL-DOUGLAS-HARALSON: Phil C. Astin; J. L. Boss; GEORGIA MEDICAL SOCIETY: John L. Elliott; J. Patrick Evans; F. Debele Maner; Joseph A. Mulherin; William G. Sutlive; Alton F. Williams; J. Randall Winburn, Jr.; CHATTAHOOCHEE: Rupert H. Bramblett; CHEROKEE-PICKENS: C. J. Roper; CRAWFORD W. LONG: F. M. McElhannon; CLAYTON-FAYETTE: Wells Riley; COBB: Remer Y. Clark; Luther Fortson; James H. Manning; Stephen C. May; Noah D. Meadows; Donald R. Rooney; COWETA: Robert Jarrell; DEKALB: John P. Heard; Phillip M. Jardina; Ellis B. Keener; Frank Mathews; M. Hobson Rice; Roger R.



Miss Thelma Franklin, MAG Business Manager and Miss Camille Day, MAG Staff Secretary, at the registration desk in the Savannah Inn.

Rowell; Luther M. Vinton; Charles B. Watkins; DOUGHERTY: Lawrence T. Crimmins; D. Allen Turner; Robert Waller; CAMDEN-CHARLTON: R. R. McCollum; EMANUEL: R. J. Moye; FLINT: J. T. Christmas; FLOYD: A. Richard Gray; W. Henry Lucas; James H. Smith; FULTON: John T. Godwin; J. Frank Walker; Linton H. Bishop; Robert E. Wells; Fleming L. Jolley; Joseph S. Wilson; John S. Atwater; Edwin C. Evans; L. Newton Turk, III; Irving L. Greenberg; Harrison L. Rogers; A. A. Rayle, Jr.; Spencer S. Brewer; William D. Longa; Charles E. Todd; Charles B. Upshaw, Jr.; Don F. Cathcart; William L. McDougall, Jr.; Robert Finegan; F. William Dowda; Frank L. Wilson, Jr.; William W. Moore, Jr.; Thomas Anderson, Jr.; John Rhodes Haverly; Joseph L. Girardeau; William E. Huger, Jr.; J. G. McDaniel; Perry White; John N. McClure; Harold S. Ramos; Milton B. Satcher; C. R. Moorhead; Joseph A. Hertell; John Schellack; James A. Kaufmann; GLYNN: C. S. Britt; J. L. Hunt; HABERSHAM: Thomas N. Lumsden; HALL: B. S. Hardman; A. Fred Bloodworth; PEACH BELT: Virgil F. McEver; JACKSON-BANKS: E. W. Holloway; JEFFERSON: C. Roy Williams; LAURENS: W. M. Watkins; MERIWETHER-HARRIS: J. Emmett Collins; MUSCOGEE: Jack Hirsch; Henry H. Boyter; Luther J. Smith; NEWTON-ROCKDALE: J. R. Sams; OCONEE VALLEY: C. H. Dickens; OCMULGEE: W. E. Coleman; POLK: Don Schmidt; RANDOLPH-

STEWART-TERRELL: W. G. Elliott; RICHMOND: Norman Pursley; Daniel B. Sullivan; Henry D. Scoggins; Walter L. Sheppard; Stuart H. Prather, Jr.; Ronald F. Galloway; Preston D. Ellington; William A. Fuller; Menard Ihnen; SOUTH GEORGIA: H. Briggs Smith; Joe C. Stubbs; SPALDING: James Skinner; Alex P. Jones; STEPHENS: Irving Hellenga; SUMTER: E. W. Waldemayer; THOMAS-BROOKS: F. R. Miller; D. J. McKenzie; TIFT: James F. Kirkpatrick; TROUP: H. Hilt Hammett, Jr.; Charles T. Cowart; UPSON: T. A. Sappington; WALKER-CATOOSA-DADE: Robert T. Jones; WARE: L. C. Durrenence; Floyd E. Davis; WASHINGTON: J. E. Lever; WAYNE: O. O. McGahee; WHITFIELD: E. T. McGhee; M. B. Lumpkin; WILKES: M. C. Adair; WORTH: H. G. Davis, Jr.

Credentials and Tellers Committee

Speaker Rogers announced the prior appointment of the House of Delegates Credentials Committee and the appointment of the Tellers Committee as follows:

CREDENTIALS COMMITTEE: John T. Godwin, Atlanta, Chairman; Irving D. Hellenga, Toccoa, Vice-Chairman; M. Hobson Rice, Decatur.

TELLERS COMMITTEE: T. A. Sappington, Thomaston, Chairman; Donald R. Rooney, Marietta; and John T. Hoover, Rossville.

Reference Committees

Speaker Rogers appointed the following House of Delegates Reference Committees:

REFERENCE COMMITTEE NO. 1: Murray B. Lumpkin, Dalton, Chairman; M. C. Adair, Washington, Vice-Chairman; J. Randall Winburn, Savannah; L. Newton Turk, III, Atlanta; Daniel B. Sullivan, Augusta; H. L. Dismuke, Ocilla.

REFERENCE COMMITTEE NO. 2: H. G. Davis Jr., Sylvester, Chairman; Rupert H. Bramblett, Cumming, Vice-Chairman; Edwin C. Evans, Atlanta; H. Hilt Hammett, LaGrange; C. S. Britt, Brunswick; William D. Logan, Atlanta.

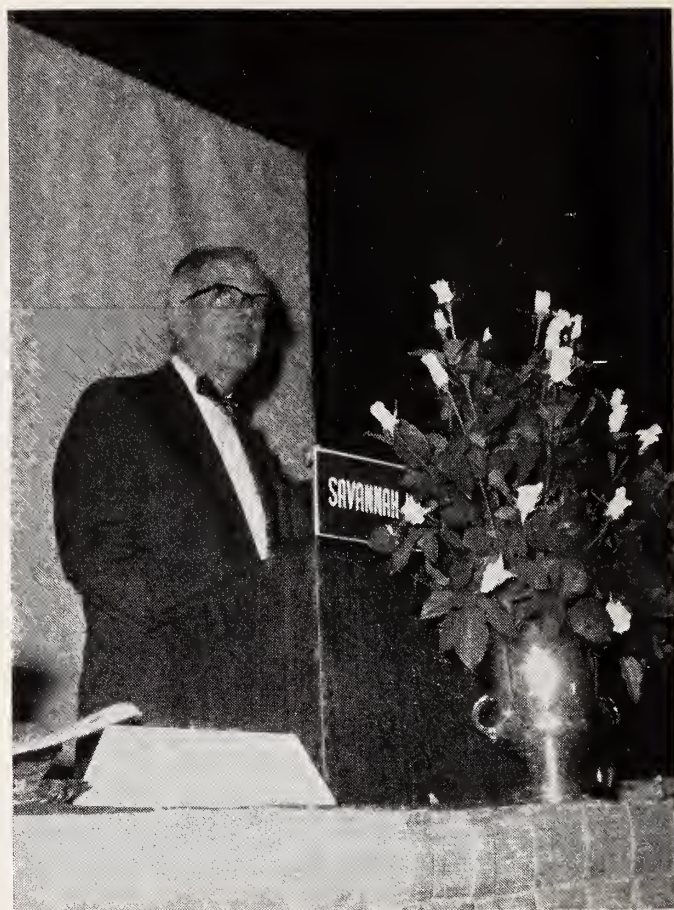
REFERENCE COMMITTEE NO. 3: Charles B. Watkins, Chamblee, Chairman; Stuart H. Prather, Augusta, Vice-Chairman; O. O. McGahee, Jesup; Joseph A. Mulherin, Savannah; J. Harold Harrison, Atlanta; Robert S. Robinson, Metter.

REFERENCE COMMITTEE NO. 4: James H. Manning, Marietta, Chairman; William E. Huger, Jr., Atlanta, Vice Chairman; Luther Vinton, Decatur; B. S. Hardman, Gainesville; Alex P. Jones, Griffin; James H. Smith, Rome.

REFERENCE COMMITTEE NO. 5: T. J. Anderson, Atlanta, Chairman; Charles G. Burton, Macon, Vice-Chairman; Phil C. Astin, Carrollton; T. N. Lumsden, Clarkesville; Spencer S. Brewer, Atlanta; Jack A. Raines, Columbus.

Approval of 1968 Minutes

To expedite the reading and adoption of the minutes of the 1968 Sessions of the House of Delegates held in conjunction with the 114th Annual Session



Harrison L. Rogers, M.D., presides as Speaker of the House of Delegates.

of the Medical Association of Georgia convened on May 6-7, 1968, at the Augusta Town House Motor Inn, in Augusta, Georgia, the Chair entertained a motion that the minutes as published in the June 1968 issue of the *Journal of the Medical Association of Georgia* be approved. On motion duly made and seconded, it was voted that these minutes be so approved as published in their entirety in the June 1968 issue of the *JMAG*.

Annual Reports

Speaker Rogers called for the Annual Reports of Officers, Council, Councilors and Vice-Councilors, AMA Delegates, Association Committees and other reports as introduced at this Session, which are listed below with the reference committees to which they were referred. The full report; the action of the reference committee, and the House of Delegates action is listed under the proceedings of the Second Session of the House of Delegates. (See pages 234 to 296.)

REPORTS OF OFFICERS

President—Reference Committee No. 2
 President-Elect—Reference Committee No. 2
 First Vice-President—Reference Committee No. 1
 Second Vice-President—Reference Committee No. 3

Secretary—Reference Committee No. 1
 Treasurer—Reference Committee No. 2
 Speaker of the House—Reference Committee No. 1
 Vice-Speaker of the House—Reference Committee No. 4
 AMA Alternate Delegate (Dowda)—Reference Committee No. 3
 Chairman of Council—Reference Committee No. 3
 AMA Delegates (Chambers)—Reference Committee No. 3

COUNCILORS AND VICE-COUNCILORS

First District Councilor—Reference Committee No. 5
 Second District Councilor—Reference Committee No. 5
 Third District Councilor—Reference Committee No. 5
 Sixth District Councilor—Reference Committee No. 5
 Seventh District Councilor—Reference Committee No. 5
 Seventh District Vice-Councilor—Reference Committee No. 1
 Eighth District Councilor—Reference Committee No. 1
 Ninth District Councilor—Reference Committee No. 1
 Tenth District Councilor—Reference Committee No. 1
 Tenth District Vice-Councilor—Reference Committee No. 1
 Bibb County Medical Society Councilor—Reference Committee No. 1
 Cobb County Medical Society Councilor—Reference Committee No. 2
 Cobb County Medical Society Vice-Councilor—Reference Committee No. 1
 DeKalb County Medical Society Councilor and Vice-Councilor—Reference Committee No. 4
 Fulton County Medical Society Councilor (Godwin)—Reference Committee No. 5
 Fulton County Medical Society Councilor (Harrison)—Reference Committee No. 3
 Fulton County Medical Society Councilor (Jolley)—Reference Committee No. 2
 Georgia Medical Society Councilor—Reference Committee No. 5
 Muscogee County Medical Society Councilor—Reference Committee No. 1
 Richmond County Medical Society Councilor—Reference Committee No. 2

STANDING COMMITTEES

Annual Session—Reference Committee No. 4
 Constitution and Bylaws—Reference Committee No. 3
 Finance—Reference Committee No. 2
 Professional Conduct and Medical Ethics—Reference Committee No. 1
 Traffic Safety—Reference Committee No. 5
 Woman's Auxiliary Advisory—Reference Committee No. 4

SPECIAL COMMITTEES

Blood Banks—Reference Committee No. 4
 Cancer—Reference Committee No. 1
 Disaster Medical Care—Reference Committee No. 5
 Hospital Activities—Reference Committee No. 4

Insurance and Economics—Reference Committee No. 2
 Legislation
 National—Reference Committee No. 3
 State—Reference Committee No. 3
 Maternal and Infant Welfare—Reference Committee No. 4
 Medical Education—Reference Committee No. 2
 Medical Review and Negotiating—Reference Committee No. 2
 Medicine and Religion—Reference Committee No. 5
 Mental Health—Reference Committee No. 5
 Nursing Liaison—Reference Committee No. 4
 Occupational Health—Reference Committee No. 3
 Allied Health Careers—Reference Committee No. 5
 Physician-Lawyer Liaison—Reference Committee No. 3
 Public Service—Reference Committee No. 5
 Rural Health—Reference Committee No. 5
 School Child Health—Reference Committee No. 3
 Separate Billing—Reference Committee No. 3
 Talmadge Hospital Liaison—Reference Committee No. 5
 Title XIX—Reference Committee No. 2
 MAG Headquarters Building—Reference Committee No. 5
 Special Finance—Reference Committee No. 2
 Historical—Reference Committee No. 1
 Awards—Reference Committee No. 3

OTHER REPORTS

Report of the *Journal*—Reference Committee No. 1
 Woman's Auxiliary to the Medical Association of Georgia—Reference Committee No. 4
 Georgia Regional Medical Program—Reference Committee No. 4

General Practitioner of the Year Award

Speaker Rogers then announced the nominations for the 1969 Georgia General Practitioner of the Year Award as received in the Association's Headquarters at least two weeks prior to the opening of the Annual Session. The nominees were: Reuben S. O'Neal, M.D., LaGrange; William Alfred Mendenhall, M.D., Chamblee; and Abraham Germain, M.D., Atlanta. Dr. Rogers then asked the delegates to mark their "GP of the Year" ballot with the name of the candidate of their choice. The Tellers Committee then reported that Dr. Reuben S. O'Neal of LaGrange, Georgia, had been elected the 1969 "General Practitioner of the Year" and Speaker Rogers announced that this award would be presented at the final MAG General Session on Wednesday, May 7.

Unfinished Business

Speaker Rogers announced that under the heading of unfinished business, he wished to call special attention to the "Incoming President's Address" de-



Reuben S. O'Neal of LaGrange accepts the General Practitioner of the Year Award from Irving Hellenga, president of the Georgia Academy of General Practice.

livered earlier in the morning by President-Elect John Kirk Train, Jr.

Supplemental Reports

Speaker Rogers proceeded with unfinished business, presenting supplemental reports for referral to House of Delegates reference committees. Dr. Rogers stated that a supplemental report adds additional data to the original report already submitted and included in the House of Delegates Handbook. Supplemental Reports were then referred as follows:

Supplemental Report 69-1: Hospital Activities Committee—Reference Committee No. 4

Supplemental Report 69-2: Chairman of Council—Reference Committee No. 2

New Business—Resolutions

Speaker Rogers stated that at this time, the House of Delegates would consider new business which concerned the introduction of Resolutions. The following Resolutions were then presented:

Resolution No. 1: Training of Family Physicians—Reference Committee No. 3

Resolution No. 2: Diagnostic and Therapeutic Services Under Qualified Physician Direction and Control—Reference Committee No. 1

Resolution No. 3: Changes Brought About by Reapportionment of Districts in the Unit Organization of District Medical Societies—Reference Committee No. 3

Resolution No. 4: Continuing Education for Allied Health Personnel—Reference Committee No. 5

Resolution No. 5: Nursing Education—Reference Committee No. 4

Resolution No. 6: Policy on Chiropractic—Reference Committee No. 3

Resolution No. 7: Study by MAG of Hospital Medical Staff Organization and Operation—Reference Committee No. 4

Resolution No. 8: Direct Billing Under Medicaid—Reference Committee No. 3

Resolution No. 9: Amendments to Medical Practice Act to Prescribe Standards for the Licensing of Osteopaths to Practice Medicine—Reference Committee No. 3

Resolution No. 10: GaMPAC Commendation—Reference Committee No. 5

Speaker Rogers then called for additional Resolutions, and there being none, the First Session of the MAG House of Delegates was recessed on motion duly made and seconded at 10:05 a.m.

TRUSTEES HOLD ANNUAL MEETING

The annual meeting of the trustees of the Medical College of Georgia Foundation, Inc. was held in Savannah in May.

New officers elected for a one-year-term are as follows: Irving Victor, M.D., of Savannah, President; J. G. McDaniel, M.D., of Atlanta, first Vice-President; Jule C. Neal, Jr., M.D., of Macon, second Vice-President; Robert T. Anderson, M.D., of Dublin, Secretary-Treasurer; Robert G. Ellison, M.D., of Augusta, Trustee; and Edgar R. Pund, M.D., of Seneca, South Carolina, Director.

EXECUTIVE COMMITTEE AND COUNCIL SELECT 1969-70 MAG LEADERSHIP

At organizational meetings following adjournment of the 115th Annual Session of MAG in Savannah, the Council and Executive Committee of Council selected the leaders of MAG for 1969-70. Council chose as its Chairman for this year C. E. Bohler, M.D., of Brooklet. Vice-Chairman will be Paul T. Scoggins, M.D., of Commerce. Chosen again as Editor of the *JMAG* was Edgar Woody, M.D., of Atlanta. The Finance Committee will be composed of Braswell Collins, M.D., Macon, chairman; Roy L. Gibson, M.D., Columbus; and Floyd R. Sanders, M.D., Decatur.

The Executive Committee voted to recommend the appointments of John S. Atwater, M.D., Atlanta, as treasurer, and Mr. Edwin F. Smith, Stone Mountain, as executive secretary for 1969-70. These were confirmed by the Council. The Executive Committee will be presided over by President John Kirk Train, Jr., M.D., Savannah.

MAG General Assembly

115th Annual Session of the Medical Association of Georgia

Monday, May 5, 1969

THE GENERAL ASSEMBLY of the 115th Annual Session of the Medical Association of Georgia was called to order by President Charles R. Andrews, Jr., Canton, at 10:30 a.m., in the Ballroom, Savannah Inn and Country Club, Savannah, on May 5, 1969.

Dr. Andrews explained to the MAG members, Auxiliary members, and guests present that the purpose of this MAG General Assembly would be to hear a special address by the President of the American Medical Association, Dr. Dwight Wilbur, of California, and a special address by the Honorable Edward J. Gurney, United States Senator from Florida.

To introduce the President of the American Medical Association, Dr. Andrews recognized a delegate to the AMA from Georgia, Dr. J. Frank Walker. Dr. Walker introduced Dr. Dwight L. Wilbur, who delivered his address to the General Assembly entitled, "Re-organization, Objectives and Changes in the AMA."

President Andrews then announced that Senator Gurney's flight had been delayed, and he expressed regret that the Senator would be unable to appear on the General Assembly program.



Milford O. Rouse (center), immediate past president of AMA, chats with J. Frank Walker, president of Fulton County Medical Society and John Kirk Train, MAG president.

President Andrews announced that this would close the General Assembly, and declared the meeting adjourned.

CALENDAR OF MEETINGS

In Georgia

June 27-July 3—Annual Meeting of the American Society of Radiologic Technologists, Regency-Hyatt House, Atlanta.

Sept. 15-16—Annual Scientific Session of the Georgia Heart Association, DeSoto-Hilton Hotel, Savannah.

In the Nation

June 18-22—American Rheumatism Association, Statler-Hilton Hotel, Boston, Mass.

June 19-21—American Medical Women's Association, Alta Mira Hotel, Sausalito, Calif.

June 23-26—American Orthopaedic Association, The Homestead, Hot Springs, Va.

June 25-28—Society of Nuclear Medicine, Jung Hotel, New Orleans, La.

June 28-29—American Diabetes Association, Hotel Roosevelt, New York, N.Y.

July 2-7—International College of Surgeons, United States Section (Annual Midsummer Meeting), Whiteface Inn, Lake Placid, N.Y.

July 12—American Association for the Study of Headache, New York Hilton, New York, N.Y.

July 13-17—American Medical Association Annual Meeting, New York, N.Y.

July 21-23—Postgraduate Medical Assembly of South Texas, Shamrock Hilton Hotel, Houston, Tex.

July 28-Aug. 1—Southern Obstetric and Gynecologic Seminar, Grove Park Inn, Asheville, N.C.

Aug. 18-21—American Hospital Association, International Amphitheatre, Chicago, Ill.

MAG Annual Banquet

115th Annual Session of the Medical Association of Georgia

Tuesday, May 6, 1969

THE ANNUAL BANQUET of the 115th Annual Session of the Medical Association of Georgia was presided over by President Charles R. Andrews, Jr., Canton, in the Ballroom, Savannah Inn and Country Club, Savannah, Georgia, on May 6, 1969. Serving as Master of Ceremonies for the evening was Henry S. Jennings, M.D., Gainesville.

Speaker's Table

Following dinner, Master of Ceremonies Jennings introduced those sitting at the head table as follows: President Charles R. Andrews, Jr. and Mrs. Andrews; President-Elect John Kirk Train and Mrs. Train; Chairman of Council F. G. Eldridge and Mrs. Eldridge; President of MAG Auxiliary Mrs. Hayward Phillips and Dr. Phillips; President-Elect of MAG Auxiliary, Mrs. S. William Clark and Dr. Clark; Georgia Medical Society President John G. Zirkle and Mrs. Zirkle; Georgia Medical Society Local Arrangements Chairman Lee Howard, Jr. and Mrs. Howard; Georgia Medical Society Convention Co-Chairman, Mrs. Walter Brown and Dr. Brown, and his wife, Mrs. Jennings.

AMA-ERF

Dr. Jennings then announced that as evidence of the Association's and organized medicine's vital and continuing interest in Georgia's two outstanding medical schools, that he would present unrestricted grant monies raised by contributions from physicians and woman's auxiliaries during the year 1968 to representatives of the two medical schools. Dr. Jennings called for Dr. Harry O'Rear, President of the Medical College of Georgia, to come forward and receive a check in the amount of \$5,079.20 for the Medical College of Georgia. Dr. Jennings then called for Dr. Evangeline Papageorge, Associate Dean, Emory University School for Medicine, to come forward to accept a check in the amount of \$5,796.80 for the Emory University School of Medicine.

Certificate of Appreciation

Dr. Jennings then stated that he wished to present a Medical Association of Georgia Certificate of Ap-

preciation to the President of the Woman's Auxiliary to the MAG, Mrs. Hayward S. Phillips, of Augusta.

50-Year Certificates

Dr. Jennings then called on Immediate Past President John T. Mauldin to present MAG 50-Year Certificates and Pins to physician members who had practiced medicine for 50 years or more. These presentations were made to the following physicians:

William E. Campbell, Jr., Atlanta; Robert Drane, Savannah; M. A. Ehrlich, Bainbridge; Robert C. Goolsby, Jr., Macon; Walter R. Holmes, Atlanta; William P. Nicholson, Jr., Atlanta; A. A. Rogers, Sr., Commerce; Robert L. Rogers, Gainesville; Albert F. Saunders, Valdosta; and David C. Williams, Macon.

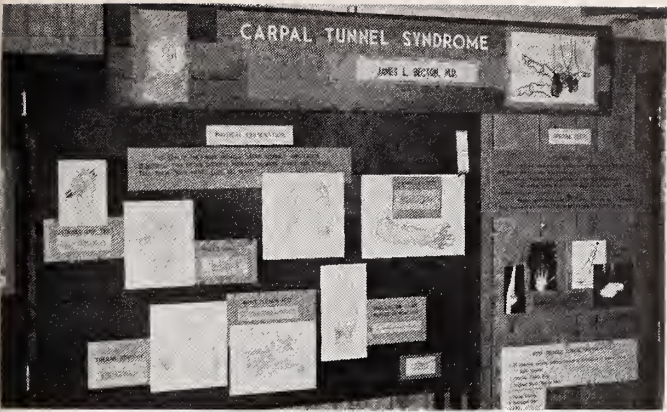
Certificates of Appreciation

Dr. Jennings then presented Medical Association of Georgia Certificates of Appreciation to persons recognized by the Association for their activities in behalf of the Medical Association of Georgia. Certificates were presented to the following:

Charles R. Andrews, Jr., M.D., as MAG President, 1968-69; Fleming L. Jolley, M.D., as First Vice-President, 1968-69; William Rawlings, M.D., as 6th and 10th District Councilor, 1962-69; Harry D. Pinson, M.D., as Richmond County Medical Society Councilor, 1962-69; Cyrus W. Strickler, Jr., M.D., as MAG Selective Service Representative for 15 years; Representative George L. Smith, as Speaker of the House of the Georgia General Assembly; Charles Eberhart, M.D., as Chairman, MAG Nursing Liaison Committee, 1967-69; J. G. McDaniel, M.D., as Chairman, Headquarters Building Committee, 1968-69; Earnest C. Atkins, M.D., as Chairman, Georgia Medical Political Action Committee; F. G. Eldridge, M.D., as Chairman of Council, 1967-69; and John A. Bell, M.D., as a member, University System Board of Regents, 1963-69.

Scientific Exhibits Awards

John N. McClure, Atlanta, Chairman of the Association's Scientific Exhibits Committee, was then called on by Dr. Jennings to make the following presentations:



"Carpal Tunnel Syndrome" won the First Place Award for scientific exhibits.

- First Place Award—"Carpal Tunnel Syndrome—Diagnosis and Management"
James L. Becton, M.D., Augusta, Georgia
- Second Place Award—"Clinical Cytogenetics"
John T. Godwin, M.D., and Nan O. Putman, C.T. (ASCP), Atlanta, Georgia
- Third Place Award—"The Pigmented Mole"
Committee on Cutaneous Health and Cosmetics, American Medical Association, Chicago, Illinois.

Golf Prizes

Dr. Jennings then called on Dr. Jeff Holloman to present prizes to the winners of the MAG Annual Session Golf Tournament. Awards went to the following winners:

- First Place—W. D. Lundquist, Savannah
- Runner-up—Duncan Walker, Macon
- Handicapped Division: J. J. Holloman, Savannah (low net); H. Hilt Hammett, LaGrange

Tennis Prizes

Dr. Jennings then called on Dr. R. L. Schley, Chairman of the Tennis Tournament, to present awards to the following winners:

- First Place—Irving L. Greenberg, Atlanta
- Runner-up—Edgar D. Grady, Atlanta

Art Exhibit Prizes

Dr. Jennings recognized MAG Vice-President Ronald Galloway to present the prizes for the best exhibits in the First Annual Session Art Exhibit. Prizes were awarded as follows:

- First Place—Mrs. C. Lamott Osteen
- Second Place—Dr. Preston D. Ellington
- Third Place—Dr. Joseph Hertell
- Fourth Place—Mrs. E. F. Rosen

President's Key and Bound MAG Journal

Chairman Jennings then asked outgoing President Charles R. Andrews, Jr. to come to the podium

where he was presented with his President's Key and a bound volume containing the issues of the *Journal of the Medical Association of Georgia* published during his term as President.

Incoming President

President Andrews expressed his appreciation to the Medical Association of Georgia for the opportunity of serving as its President, and asked that President-Elect John Kirk Train join him at the podium. Dr. Andrews then recognized the fact that Dr. Train would be installed with other officers of MAG at the General Business Session on Wednesday, May 7, but stated that he wished symbolically to pass the gavel of office to Dr. Train as incoming President.

Dr. Train received the gavel of office, and expressed his appreciation to MAG for the trust demonstrated by his election as President-Elect.

Entertainment

Dr. Train then turned the meeting back over to Master of Ceremonies Henry S. Jennings, who introduced the entertainment for the evening, Doraine and Ellis, with their cavalcade of music and outstanding Broadway productions.



Outgoing President Andrews passes the gavel to incoming President John Kirk Train of Savannah.

Second Session, House of Delegates

Wednesday, May 7, 1969

(RECONVENED)

THE SECOND SESSION (reconvened) of the House of Delegates of the Medical Association of Georgia held in conjunction with the 115th Annual Session of the Association was called to order by Speaker Harrison Rogers at 10:05 a.m., in the Ballroom, Savannah Inn and Country Club, Savannah, Georgia, on May 7, 1969.

Speaker Rogers called for a report on attendance from the Credentials Committee. Dr. Irving Hellenga, Vice-Chairman of the Credentials Committee, reported that 109 delegates were present and registered, representing 39 component county medical societies. Dr. Hellenga reported that since 40 members of the House constitute a quorum, business could proceed. Speaker Rogers declared a quorum present and the House of Delegates duly in session. The Credentials Committee made the following complete report on attendance at the close of the meeting.

Attendance

In a compilation of attendance taken from the official roll, 39 component county medical societies were represented by their duly elected delegates or alternates. Of a total of 165 authorized delegates from their respective medical societies, the official roll showed 109 delegates present at this Second Session.

BIBB: Henry Tift; Charles A. Lanford; Hugh F. Smisson; Charles G. Burton; F. V. Kay; W. A. Bootle; OGEECHEE RIVER: Robert S. Robinson; CARROLL-DOUGLAS-HARALSON: Phil C. Astin; J. L. Boss; GEORGIA MEDICAL SOCIETY: John L. Elliott; Alton F. Williams; William G. Sutlive; J. Patrick Evans; CHATTAHOOCHEE: Rupert H. Bramblett; CHEROKEE-PICKENS: C. J. Roper; CRAWFORD

W. LONG: F. M. McElhannon; CLAYTON-FAYETTE: Wells Riley; COBB: Remer Y. Clark; Stephen C. May; James H. Manning; Luther Fortson; COWETA: R. J. Jarrell; DEKALB: M. Hobson Rice; Luther M. Vinton; John P. Heard; Phillip M. Jardina; Charles B. Watkins; Frank Matthews; Roger R. Rowell; DOUGHERTY: Lawrence T. Crimmins; D. Allen Turner; EMANUEL: R. J. Moye; FLINT: J. T. Christmas; FLOYD: A. Richard Gray; James H. Smith; W. Henry Lucas; FULTON: J. Frank Walker; Robert E. Wells, Fleming L. Jolley; Joseph S. Wilson; John S. Atwater; Edwin C. Evans; L. Newton Turk, III; Irving L. Greenberg; Harrison L. Rogers; A. A. Rayle, Jr.; J. Harold Harrison; Spencer S. Brewer; William D. Longa; Charles E. Todd; Charles B. Upshaw, Jr.; William L. McDougall, Jr.; F. William Dowda; Frank L. Wilson, Jr.; William W. Moore, Jr.; J. Rhodes Haverty; Joseph L. Girardeau; Edwin C. Pound; William E. Huger, Jr.; J. G. McDaniel; Perry White; John N. McClure, Jr.; Harold S. Ramos; C. R. Moorhead; Joseph A. Hertell; John Schellack; James A. Kaufmann; GLYNN: J. L. Hunt; HABERSHAM: Thomas N. Lumsden; HALL: C. W. Whitworth; B. S. Hardman; A. Fred Bloodworth; PEACH BELT: Virgil F. McEver; JACKSON-BANKS: E. W. Holloway; JEFFERSON: C. Roy Williams; LAURENS: W. M. Watkins; MUSCOGEE: Jack A. Raines; Jack Hirsch; Henry H. Boyter; Luther J. Smith; RANDOLPH-STEWART-TERRELL: W. G. Elliott; RICHMOND: J. L. Mulherin; Daniel B. Sullivan; Henry D. Scoggins; Walter L. Sheppard; Stuart H. Prather, Jr.; Julius T. Johnson; Ronald F. Galloway; Preston D. Ellington; William A. Fuller; Menard Ihnen; Norman Pursley; SOUTH GEORGIA: H. Briggs Smith; Joe C. Stubbs; SOUTHEAST GEORGIA: George P. Sassos; SPALDING: James Skinner; Alex P. Jones; STEPHENS: Irving Hellenga; SUMTER: J. H. Robinson, III; TIFT: James F. Kirkpatrick; TROUP: H. Hilt Hammett; Charles T. Cowart; UPSON: T. A. Sappington; WALKER-CATOOSADADE: Robert T. Jones; WARE: L. C. Durrence; Floyd E. Davis; WAYNE: O. O. McGahee; WHITFIELD: E. T. McGhee; WORTH: H. G. Davis, Jr.

Reference Committee Reports

Speaker Rogers then called for reports from the reference committee chairmen. Speaker Rogers explained to the House that reports from the reference committee chairmen would be presented in the form of a motion on the floor, and if no discussion or dissent was heard following each portion of the reference committee report in which a recommendation is made by the reference committee, the Chair would rule the item adopted as read and presented pending final vote on the entire report.

Report of Reference Committee No. 1

Murray B. Lumpkin, M.D. Chairman

(The following reports as presented to this reference committee are printed in full with the reference committee's recommendations and the action pursuant to them taken by the House of Delegates.)

Chairman Lumpkin reported to the House that reports and resolutions referred to Reference Committee No. 1 had been considered by the committee which convened at 9:15 a.m., in the Pebble Beach Room of the Savannah Inn and Country Club in Savannah, on May 6, 1969. Members of the committee present included Murray Lumpkin, Dalton, Chairman; Newton Turk, Atlanta, Acting Vice-Chairman; Daniel B. Sullivan, Augusta; and J. Randall Winburn, Savannah.

First Vice-President

FLEMING L. JOLLEY, M.D., Atlanta

Due to the continued good health of your president, for which everyone is thankful, the activities of the first vice-president have been limited to the deliberations of the Council and Executive Committee.

It has been a pleasure to work with and for the members of this organization. My thanks to each of you who have made this possible.

No specific recommendations are made by your first vice-president.

REFERENCE COMMITTEE RECOMMENDATION
—Your reference committee recommends approval of the report of the First Vice-President.

HOUSE OF DELEGATES ACTION—Adopted the report of the reference committee as presented.

Secretary

JOHN RHODES HAVERTY, M.D., Atlanta

The duties imposed on the secretary by the MAG Constitution and Bylaws have been carried out to the best of my ability. These consist of attending the House of Delegates Annual Session, Council meetings, and Executive Committee meetings, along with other committees when requested. Answering communications by telephone and by letter from the members of the Association, the headquarters' office staff, and the public, requires attention. A weekly meeting with the Headquarters personnel helps keep things moving smoothly.

As a part of the Finance Committee, I am responsible for helping to prepare the annual budget, particularly as it relates to salaries. Also, from a financial standpoint, along with the treasurer I co-sign all the checks written by the Association.

Our membership continues to grow, this past year at about a 4 per cent rate. A comparison of this year's and last year's membership is as follows:

Membership	12/31/68	12/31/67
Active	3,121	2,992
Affiliate	1	1
Dues Exempt	331	319
Honorary	1	1
Service	56	61
Associate	58	56
	<hr/> 3,568	<hr/> 3,430

Military Medicare (OCHAMPUS) still is operating under the aegis of the MAG, and the fine direction of Mrs. Joyce Butler; as fiscal agent, I helped guide this division of our Association. The following is a statistical summary of the past two years' experience with the program:

Number of Claims	Annual		% Total		Avg./Month		Avg./Day	
	'68	'67	'68	'67	'68	'67	'68	'67
Received	37,320	25,244	100	100	3,110	2,104	145	98
Returned	8,065	5,572	22	22	672	464	31	24
Rejected	1,754	812	5	3	146	68	6	3
Adjusted	3,553	3,520	9.5	14	296	293	13	13
Adjudicated	59	176	.1	.7	—	15	—	—
Paid	29,432	19,191	80	76	2,452	1,599	114	74
				'68		'67		
Total Dollar Amount Paid	\$2,502,695.08		\$1,361,242.97					
Average per claim	85.03		53.92					

Another division is represented by the GRMP, growing to great proportions with the inspired and innovative leadership of Dr. Gordon Barrow. As fiscal agent of this also, I sign all the checks and generally help to coordinate the GRMP with other activities and personnel of the MAG. During this year, I have been honored by being elected vice-chairman to the Regional Advisory Group of the GRMP.

At last year's annual session I recommended, along with others, the expansion of our present MAG Headquarters building. This was accepted by the House, and the building is proceeding very well indeed. We look forward to occupying our expanded new quarters in September 1969. As commented on elsewhere, most of the building will house the GRMP, which is carrying its share of the financial burden of enlarging the facilities. Interestingly enough, we purchased our present building in 1960. One wonders where we will find ourselves in another ten years of extraordinary growth and service to our profession and to our State.

Another recommendation which was accepted by the House last year was concerned with revamping the Annual Session itself. Everyone should be pleased with the great job Dr. Preston Ellington has done for this year's meeting, and his plans for the future are even more exciting.

The MAG Foundation, established last year, has the following breakdown of income and disbursements, as of February, 1969.

<i>Contributions</i>	<i>Disbursements</i>
\$1,095.00	Brochures \$405.82
	Registration 1.00
	Corporation 6.14
	Bank Charges <hr/>
Bank Balance	\$682.04

It is hoped that this fund will increase in amount and usefulness as time passes.

Dr. Frank Walker, our illustrious past speaker of this House, is running for Vice-Speaker of the House of Delegates of the AMA. Your hard-working Georgia delegation is soliciting votes vigorously, by mail and in person, toward his election. If we are successful, honor will accrue to our State and to the AMA through his charm and great abilities. The entire Association wishes him well; any personal assistance in his behalf before or during the annual convention in New York in July will be well worth the effort.

A recommendation I reiterated to this House last year was the formation of a discretionary fund for the use of the Executive Committee. This was approved, and I present here the use of this fund since that time. Expenditures from this fund have totalled \$438.78 including a \$100 item in July 1968, one for \$88.78 in October 1968, and one for \$250 in January 1969. All were considered to be necessary prior to Council's meeting some two months later.

May I digress for a moment? I would like to point out to this distinguished House three issues of interest to me. The formation of a Joint Board of Medical Examiners, and the amalgamation of osteopaths into the mainstream of Georgia medicine is a worthy goal, but extremely difficult in its attainment. Your As-

sociation officers and the Board of Medical Examiners are working to achieve this goal, keeping ever present the health of the public as the basic issue at hand. Your questions and guidance will be appreciated by all concerned, and will assure a better solution to this vexing problem.

My new field of endeavor is in attempting to educate more and better qualified personnel to help you in delivering health care to your patients. I solicit your recommendations and comments as to your needs, and I pledge you my best efforts toward providing the kinds of individuals who can ease your professional burdens and at the same time add to the efficiency with which you serve your people. Do not fear change in these areas, but open your minds and study how new ways of doing things can make life easier and better for all. We cannot stand still while the world rushes on to new frontiers; we cannot stand guarding our treasures, only to find they are treasures to no one but ourselves. Let's join the action, not fight it; with the physician's wisdom and ability to look at the total picture, let's shape the future into a better mold than that which the present now finds itself.

Finally, a short excerpt from an educational newsletter is interesting. If English professors feel this way, can we feel less? And feeling, can we not act before someone else acts for us?

"When tenure is awarded, it carries with it responsibility for the long term quality of our staff; a tenured professor cannot ignore his duty to judge his junior colleagues. A profession contains by definition an element of service—service which will not always be paid in money.

"And mainly a profession means responsible actions. As professionals, we have the duties to police our own ranks of the incompetent, the immoral, the shabby. More positively, we have the duty to reproduce our own kind, first by fostering love of learning and teaching among our students, and second, by our junior colleagues at the outset of their careers. Of course, they care for their careers, but they must be led by example and word to see that a *professional* career is a total way of life; that the fully honest scholar is also the fully honest man; that the personal concern for one's own career exists within the core of larger concerns for the department, the student, the College, the profession, and society. The man who exists only at the tiny core of 'self' is a technician and not a professional. He may have a place, but that place is not as a professor of English."

I wish to make note of the really professional staff at the MAG Headquarters office. Mr. Smith is a remarkable leader, and this, his first full year with us, has been an eminently successful stepping-stone to a greater Association. We all owe our profound thanks to him and his staff for their many efforts in our behalf, both during and after their normal working days, and to all of them, may I add my own, "Well done!"

One last comment. This year ends my first term of office as your secretary. You have honored me greatly with your trust and your support. I truly have enjoyed every minute of it, and have benefited personally and professionally, by holding this position. I thank you.

REFERENCE COMMITTEE RECOMMENDATION
—Your reference committee recommends approval with commendation of the report of the secretary.

The committee would like to point out that the increase in charges for the Military Medicare program is due to a change in coverage provided by the program which has been extended to include outpatient services and retired military personnel.

HOUSE OF DELEGATES ACTION—Adopted the report of the reference committee as presented.

Speaker, House of Delegates

HARRISON L. ROGERS, M.D., *Atlanta*

As provided in the Constitution of the Medical Association of Georgia, at the second session of the House of Delegates (May 1968) your present speaker and vice-speaker were elected to office for three years. Every effort will be made to see that the best interest of each member of the Medical Association of Georgia as represented by his delegate is served. Our plans for the physical facilities of the House of Delegates, appointments to the reference committees, participation in the work of the reference committees, representing the House of Delegates on Council and most important, carrying out the directions and will of the House shall be done to the best of our abilities.

Arrangements have been made to provide the delegates and alternates with carefully planned materials in loose-leaf form prior to the Annual Session in Savannah so that each may come better prepared to conduct the business of the House. In addition, tables will be provided to obviate the necessity for juggling the reports, resolutions, etc., being considered by the delegates.

The innovations of our past speaker, Frank Walker, with regards to the proximity of the reference committees to one another, the provision of permanent staff for each committee and the numbered lines for reports and resolutions will be continued as each has proved its worth in use.

Your speakers past and present were honored to have the annual meeting of the Southeastern Speakers Conference in Atlanta this year. Once again the benefits of informal discussion of problems common to all State medical societies will, I hope, be reflected by improvements in the deliberations of our own House of Delegates.

Your speaker and vice-speaker have represented you at meetings of Council, and in addition, the speaker has brought the views of the House to the monthly meetings of the Executive Committee of Council. I feel fortunate that our vice-speaker, Preston Ellington, is also chairman of the Annual Session Committee and has made extraordinary efforts to see that the entire Annual Session, including the House of Delegates' meetings, is revitalized.

Thank you for the honor you have given us by naming us your speaker and vice-speaker. We will give you our very best efforts.

REFERENCE COMMITTEE RECOMMENDATION
—Your reference committee recommends the approval of the report of the Speaker with commendation.

HOUSE OF DELEGATES ACTION—Adopted the report of the reference committee as presented.

Seventh District Vice-Councilor

DON W. SCHMIDT, M.D., *Cedartown*

It has been my pleasure to serve as Vice-Councilor for the Seventh District Medical Society for the past year. As a first-year vice-councilor, I have found the Council meetings very enlightening, informative, and instructive. It has been a privilege working with the Councilor, David Wells, and I have worked with him to bring back to our local district meetings important events that have transpired at the Council meetings. I feel the Council will be much more effective when each district is informed as to all pertinent matters acted on by Council. I have been privileged to attend all the Seventh District medical meetings and all Council meetings, but two. I consider it a great honor to serve my district as vice-councilor.

SEVENTH DISTRICT MEMBERSHIP

Counties and Secretaries	Members December 31, 1968		Members December 31, 1967	
	MAG	AMA Dues Paying Only	MAG	AMA Dues Paying Only
Bartow				
W. C. Holmes				
Cartersville	10	6	9	7
Carroll-Douglas-Haralson				
E. H. Grant				
Carrollton	35	33	33	30
Chattooga*				
William Hyden				
Trion			5	5
Floyd				
H. R. Connell				
Rome	83	72	77	65
Gordon				
Bill Purcell				
Calhoun	9	8	10	9
Polk				
J. F. Atha				
Rockmart	14	12	14	12
Walker-Catoosa-Dade				
W. D. Crawley				
Rossville	32	19	31	16
Whitfield				
Thomas Carey				
Dalton	38	33	39	34
	<hr/>	<hr/>	<hr/>	<hr/>
	221	183	218	178

* Chattooga has merged with Floyd.

REFERENCE COMMITTEE RECOMMENDATION
—Your reference committee recommends approval of the report of the Vice-Councilor of the Seventh District.

HOUSE OF DELEGATES ACTION—Adopted the report of the reference committee as presented.

Eighth District Councilor

F. G. ELDRIDGE, M.D., *Valdosta*

The Eighth District Councilor attended all meetings of Council, regular and called, during the past year.

Due to poor attendance by members of the District during the past several years, the officials of the District joined forces with the South Georgia Medical Society and arranged a joint business and professional meeting of medical seminar type; out-of-state speakers were invited and an excellent program was arranged and delivered.

The Eighth District has decided to return to meetings in October and April of each year.

EIGHTH DISTRICT MEMBERSHIP

Counties and Secretaries	Members December 31, 1968		Members December 31, 1967	
	MAG	AMA Dues Paying Only	MAG	AMA Dues Paying Only
Altamaha				
H. L. Morgan				
Baxley	6	6	6	6
Ben Hill-Irwin				
Roy Johnson				
Fitzgerald	8	8	7	7
Coffee				
W. R. Wills, Jr.				
Douglas	10	7	10	8
Camden-Charlton				
H. H. Robinson				
Kingsland	11	7	10	7
Glynn				
W. A. Snyder				
Brunswick	47	42	49	46
Ocmulgee				
W. E. Coleman				
Hawkinsville	15	11	15	11
South Georgia				
Henry Sherman				
Valdosta	62	47	62	48
Telfair				
D. B. McRae				
McRae	5	4	6	5
Ware				
J. W. Bickerstaff				
Waycross	42	40	43	41
Wayne				
E. L. Harrell				
Jesup	9	9	9	9
	215	181	217	188

REFERENCE COMMITTEE RECOMMENDATION
—Your reference committee recommends approval of the report of the Councilor for the Eighth District.

HOUSE OF DELEGATES ACTION—Adopted the report of the reference committee as presented.

Ninth District Councilor

PAUL T. SCOGGINS, M.D., *Commerce*

Ninth District has been represented at Council by the councilor or vice-councilor, or both, at each meeting.

Due to having fewer than five members, Rabun County had to surrender its Charter and members have joined adjacent societies.

We had a total gain of nine members in the Ninth District this year.

I wish to thank my very active vice-councilor, Robert S. Tether, for his full support.

NINTH DISTRICT MEMBERSHIP

Counties and Secretaries	Members December 31, 1968		Members December 31, 1967	
	MAG	AMA Dues Paying Only	MAG	AMA Dues Paying Only
Barrow				
R. F. Graves				
Winder	8	7	7	6
Blue Ridge				
James Haymore				
Blue Ridge	6	5	7	5
Chattahoochee				
Harry Hutchins				
Buford	22	15	20	14
Cherokee-Pickens				
Ben K. Looper				
Canton	16	13	15	15
Elbert-Franklin-Hart				
A. S. Johnson				
Elberton	22	13	24	9
Habersham				
J. B. Edwards				
Cornelia	14	10	14	11
Hall				
E. E. Estes, Jr.				
Gainesville	63	58	60	57
Jackson-Banks				
A. A. Rogers				
Commerce	10	7	9	6
Rabun				
R. J. Turner				
Clayton	4	4	2	2
Stephens				
Ken Conoley				
Toccoa	18	17	16	15
	183	149	174	140

REFERENCE COMMITTEE RECOMMENDATION
—Your reference committee recommends approval of the report of the Councilor for the Ninth District.

HOUSE OF DELEGATES ACTION—Adopted the report of the reference committee as presented.

Tenth District Councilor

WILLIAM RAWLINGS, M.D., *Sandersville*

The Councilor for the Tenth District has unfortunately been unable to attend two of the Council meetings this year because of unexpected emergencies, but the District was represented ably by the vice-councilor.

The organization of the District Society has been strengthened, and officers for the forthcoming year were nominated at the recent Athens meeting. The Fall meeting was held in Thomson with an excellent program followed by a social hour. The attendance at the District meetings is still quite small, and I have no new ideas as to how to stimulate attendance other than the continuation of good scientific programs.

Personally, in my small-town practice, I see an increasing use of government programs which, I am sure, to some extent have offered medical care to some

who otherwise would not have sought it. On the other hand, it has definitely increased the use of hospital beds.

There is a growing need for some way to decrease the amount of paper work which seems to be insurmountable in the practice of medicine. This seems to be a universal problem, but nevertheless it is one which saps vital time from one's practice.

TENTH DISTRICT MEMBERSHIP

Counties and Secretaries	Members December 31, 1968		Members December 31, 1967	
	MAG	AMA Dues Paying Only	MAG	AMA Dues Paying Only
Baldwin				
L. J. Jacobs				
Milledgeville	32	24	30	23
Crawford W. Long				
W. L. Hardman				
Athens	65	49	58	48
Jasper				
B. C. Barrow				
Monticello	3	3	3	3
Jefferson				
C. R. Williams				
Wadley	5	4	5	4
McDuffie				
T. W. Middlebrook				
Thomson	7	7	6	6
Newton-Rockdale				
E. J. Callaway				
Covington	13	7	13	8
Oconee Valley				
L. J. Wade				
Union Point	11	8	11	8
Walton				
R. M. Tankesley				
Monroe	11	9	10	8
Washington				
D. L. Holmes				
Sandersville	11	1	12	1
Wilkes				
A. D. Duggan				
Washington	6	5	6	5
	164	117	154	114

REFERENCE COMMITTEE RECOMMENDATION
—Your reference committee recommends approval of the report of the Councilor for the Tenth District.

HOUSE OF DELEGATES ACTION—Adopted the report of the reference committee as presented.

Tenth District Vice-Councilor

M. A. HUBERT, M.D., Athens

I have attended all Council meetings except one. I attended the Fall District meeting in Thomson, Georgia, and the Winter meeting in Athens, Georgia. Both meetings had good attendance and excellent programs. I have aided in the merger of Jasper County Medical Society with Baldwin County Medical Society.

REFERENCE COMMITTEE RECOMMENDATION
—Your reference committee recommends approval

of the report of the Vice-Councilor of the Tenth District.

HOUSE OF DELEGATES ACTION—Adopted the report of the reference committee as presented.

Bibb County Medical Society Councilor

BRASWELL COLLINS, M.D., Macon

SIXTH DISTRICT MEMBERSHIP

Counties and Secretaries	Members December 31, 1968		Members December 31, 1967	
	MAG	AMA Dues Paying Only	MAG	AMA Dues Paying Only
Bibb				
S. C. Neuberg				
Macon	185	153	178	157

REFERENCE COMMITTEE RECOMMENDATION
—Your reference committee recommends the approval of the report of the Councilor for Bibb County.

HOUSE OF DELEGATES ACTION—Adopted the report of the reference committee as presented.

Cobb County Medical Society Vice-Councilor

REMER Y. CLARK, M.D., Marietta

One year ago at the annual MAG meeting, I was indoctrinated as a Vice-Councilor for Cobb County. First, I would like to express my appreciation to all members of the Council for their understanding and guidance. I have attended all meetings and have acquired an education as to the working or business aspect of the MAG.

To the Councilor, Dr. W. C. Mitchell, of Smyrna, I am greatly indebted for his advice, instruction, and explanations as to the many procedures of Council.

Cobb County and Kennestone Hospital have continued to grow and to meet the demands of the medical needs; we have opened a new hospital, South Cobb Hospital, which is a great aid.

In Kennestone Hospital we opened an intensive coronary care unit and an intensive surgical care unit.

Dr. Mitchell's report will reveal the growth in membership to the society.

REFERENCE COMMITTEE RECOMMENDATION
—Your reference committee recommends the approval of the report of the Vice-Councilor for Cobb County.

HOUSE OF DELEGATES ACTION—Adopted the report of the reference committee as presented.

Muscogee County Medical Society Councilor

ROY L. GIBSON, M.D., Columbus

During this past year the Councilor for Muscogee County has attended regularly the Council meetings of MAG and reported on the activities of Council to the Executive Committee and the membership of his society.

During this past year the Muscogee County Medical Society held meetings as follows:

January—scientific program on urinary tract infections

February—scientific program on preoperative radiation therapy

March—self-employed individuals retirement trusts

April—host to the Third District Medical Society all-day scientific medical surgical symposium

May—program on "Packaged Disaster Hospital Available in Muscogee County"

September—joint meeting with the medical staff at Fort Benning, Georgia on "Obesity in Diabetes"

October—Dr. Paul Williamson, who writes *Practice for Savage Laboratories* spoke to the members and wives on his experiences throughout the world.

November—annual meeting and election of officers.

During the past year this society maintained close contact with our representatives to the Georgia legislature, and received their assistance on many occasions.

The society furnished the Commanding Officer for Packaged Disaster Hospital to set up the table of organization, in this county.

Members of this society worked with all local voluntary health agencies in both advisory and service capacities.

THIRD DISTRICT MEMBERSHIP

Counties and Secretaries	Members December 31, 1968		Members December 31, 1967	
	MAG	AMA Dues Paying Only	MAG	AMA Dues Paying Only
Muscogee				
D. M. Stewart				
Columbus	127	113	119	106

REFERENCE COMMITTEE RECOMMENDATION
—Your reference committee recommends the approval of the report of the Councilor for Muscogee County Medical Society.

HOUSE OF DELEGATES ACTION—Adopted the report of the reference committee as presented.

Professional Conduct and Medical Ethics

T. A. SAPPINGTON, M.D., *Chairman*

This committee has not had to have a meeting since the Committee Conclave held early in the year. There



Earnest C. Atkins, M.D., of Atlanta presents the GaMPAC award for the county society having the highest percentage of GaMPAC members to T. A. Sappington of Upson County.

were not as many members at the conclave as was hoped for, but it was felt that definite benefits were received by those attending the meeting.

Your chairman attended the Second National Congress on Medical Ethics held in Chicago. This was an interesting meeting and your chairman felt he received definite benefit by attending this meeting. No date has been set for a third Congress as yet.

There have been a number of problems reported to this committee this year. As you know, each complaint is referred back to the local society for action. So far all complaints have been settled locally, or are under the jurisdiction of the local society at the present time. It is not known if some of these complaints will be referred back to the State committee or not. It is hoped that all of these complaints will be settled locally, but your State committee stands ready to act if the need arises.

REFERENCE COMMITTEE RECOMMENDATION—Your reference committee recommends the approval with commendation of the report of the Professional Conduct and Medical Ethics Committee with the recommendation that Dr. Sappington publicize the activities and functions of this committee and dispense this information on a statewide level through the *Journal of the Medical Association of Georgia*.

HOUSE OF DELEGATES ACTION—Adopted the report of the reference committee as presented.

Cancer

HOKE WAMMOCK, M.D., *Chairman*

The Committee on Cancer held its first meeting July 14, 1968. Eight members of the committee were present. We reviewed the activities of the cancer program in Georgia and made plans for the second meeting September 8 as a part of the MAG Committee Conclave.

To this meeting we invited all those groups or agencies that were concerned with cancer control in the State of Georgia. This included the tumor clinic directors; liaison fellows of the Commission on Cancer of the American College of Surgeons of the Georgia Chapter; Mr. Lon Sullivan, Executive Vice President, Georgia Division of the American Cancer Society; Mr. Glenn Hogan, Executive Director of the Georgia Hospital Association; Dr. Robert Hansen, Director of the Southeastern Section U. S. Public Health Service, Section on Chronic Diseases; Dr. Howard K. Sessions, State Cancer Control Division State Public Health Department; Dr. Robert R. Smith, Assistant Director of the Regional Medical Program, and Dr. Andrew B. Mayer, Assistant Director of the American College of Surgeons.

We discussed in depth the role played by each agency or group in cancer control and what could be done to develop a more effective cancer program.

In the beginning it was pointed out that Medicaid and Medicare had brought about some reduction in the case load of the Cancer State-Aid Clinics. Dr. Sessions pointed out that there was still a large percentage of indigent patients qualifying for the State-Aid Cancer Control Program. Dr. Robert Hansen discussed how support could be obtained for cancer projects

from U. S. Public Health Service-Chronic Disease Division. These projects would be directed to the community level. Mr. Lon Sullivan reviewed the patient service program of the Georgia Division of the American Cancer Society and how this could be worked along with other agencies. Dr. Robert R. Smith discussed the Regional Medical Program. Various clinics in the State will be participating in the RMP and their activities will, in part, be patterned after the rules and regulations of the Commission on Cancer of the American College of Surgeons for the establishment of a tumor registry and clinic activities program. In view of the fact that Medicaid and Medicare may have reduced the case load of the various State-aid cancer clinics, the committee felt that all the clinics in the State should develop a positive and a more active program for cancer control, especially in view of the availability of funds from the Regional Medical Program. U. S. Public Health Service (Chronic Disease Control), American Cancer Society, and the State-Aid Cancer Control Program.

The Committee on Cancer prepared two resolutions which were presented to the Council of the MAG and the Executive Committee and which have been approved. One of these resolutions, "The Use of Routine Pap Smears on All Female Patients Admitted to Hospitals" appears in the *Journal of MAG*, February 1969, Special Issue. It is hoped that all hospitals will adopt this policy as a part of their cancer control program. Further, it would be well to consider routine proctoscopic examinations for patients above a certain age level.

The second resolution dealt with the reaffirmation of the MAG's position on the hazards of smoking and recommended that this should be publicized through TV, radio, and newspapers.

RECOMMENDATIONS

The committee urges all of those concerned with cancer control to work towards a more vigorous program with emphasis upon prevention, early detection and dissemination of information to the public and to the profession.

REFERENCE COMMITTEE RECOMMENDATION—
Your reference committee recommends approval with commendation of the report of the Committee on Cancer with the following insertion from the "Addendum to the Report" prepared by the Chairman of the Committee on Cancer:

Insert after paragraph 4: "The chairman of the committee met with these same advisors recently and explored the problem of developing a more cohesive program of cancer control with all agencies in the State, discussing ways and means of new approaches and methods of implementation. They considered the problem of year-round cancer detection for cancer of the cervix, breast, and colon-rectum . . . this in preference to so-called one-day mass screening. However, there are good points to be said for each method of approach, the main point being that as yet we are not reaching those individuals of the low income group who are often seen too late with cancer.

"We urge support and cooperation with the Regional Medical Program for cancer in the development of a program of continuing education, both for the laity and the profession."

HOUSE OF DELEGATES ACTION—Adopted the report of the reference committee as presented.

Historical

MILFORD HATCHER, M.D., *Chairman*

The Historical Committee was appointed on June 3, 1967, following a request that MAG sponsor a marker for Dr. Lindsey Durham. The committee has obtained the information regarding Dr. Durham and has been working with the History Department of the University of Georgia on the possibility of writing a composite history of medicine in Georgia.

RECOMMENDATIONS

This committee recommends that the committee not only have the duty of investigating historical data regarding prominent physicians of the State of Georgia but it recommends that:

(1) This committee be given the authority and function to compile a history of medicine in Georgia;

(2) That they work with the History Department of the University of Georgia in Athens in compiling and storing this data in the library at Athens for the benefit of anyone reviewing historical medical data;

(3) That this committee be authorized to investigate the feasibility and expense connected with preparing for public exhibit instruments, data, etc., of early physicians' offices and collections which might be of museum value.

REFERENCE COMMITTEE RECOMMENDATION—
Your reference committee recommends the approval of the report of the Historical Committee with commendation.

HOUSE OF DELEGATES ACTION—Adopted the report of the reference committee as presented.

The Journal

EDGAR WOODY, JR., M.D., *Editor*

The 1968-69 report of the *Journal of the Medical Association of Georgia* is submitted herewith.

PERSONNEL

Since our last annual report Miss Frances Shinnick submitted her resignation as Managing Editor to accept a position as a housewife. Even though her tenure was only for a period of one year, the quality of her work was outstanding.

We have been fortunate to secure Miss Kay Rucker as our new Managing Editor. Miss Rucker, like Miss Shinnick, is a graduate of Hollins College and brought with her two years' experience in the editorial field prior to coming with the *Journal* in June of 1968. Her work performance has been excellent and it is hoped that she will remain with us for a long time.

STATE MEDICAL JOURNAL ADVERTISING BUREAU

While the general volume of advertising in most medical periodicals has been cut back moderately in the past year, our non-profit bureau in Chicago has been successful in holding these cutbacks to a minimum in the State Journal Group. The bureau utilizes the services of an outstanding three-man sales force led by Mr. John Murphy who formerly headed up

the advertising staff for all AMA publications. We are looking forward to a seminar for the fall of 1969 in Chicago to be sponsored by the State Medical Journal Advertising Bureau. This meeting is held every other year and is quite helpful as an informational and training seminar for all of the State editors.

ADVERTISING

As mentioned above, our national advertising volume has shown a moderate decrease over the past 12 months, while our local advertising has remained essentially unchanged. In order to balance this moderate cutback in advertising volume our editorial content has been reduced slightly in an effort to control costs and to keep within our budget.

CREDITS

Thanks are always in order for the assistance of the Publications Committee in guiding our *Journal* policy through the year just past. Our Contributing Editors have to play a key role in carrying on the work of the *Journal*. Their contributions are vital and are much appreciated. Our President's Page has maintained a high standard of excellence throughout the year and much credit is due him for his contributions. The editors and contributors of our specialty pages have kept these features both interesting and timely.

The Headquarters office staff with their continuing help have been vital in the publication of the *Journal* and their efforts are much appreciated.

REFERENCE COMMITTEE RECOMMENDATION—Your reference committee recommends approval of the report of the *Journal of the Medical Association of Georgia*.

HOUSE OF DELEGATES ACTION—Adopted the report of the reference committee as presented.

Resolution No. 2

DIAGNOSTIC AND THERAPEUTIC SERVICES UNDER QUALIFIED PHYSICIAN DIRECTION AND CONTROL

DeKalb County Medical Society

WHEREAS, technological developments, such as automation, computers, patient monitors, and the like in recent years have made great changes in the practice of medicine, usually to the benefit of patients; and

WHEREAS, said developments have made it possible for technologists, inhalation therapists, and nurse-midwives, EKG technicians, intensive care nurses, and other non-physician personnel to render valuable diagnostic and therapeutic services to patients; and

WHEREAS, industry has begun to use these developments and personnel to provide medical services to patients for profit, and with no guarantee of medical supervision, in laboratories and diagnostic centers; and

WHEREAS, advertisement of such services has appeared in the *Journal of the American Medical Association*,

THEREFORE BE IT RESOLVED that all procedures for the diagnosis and treatment of patients should be under qualified physician direction and control; and

THAT all developments, distribution, and advertis-

ing of such procedures should be in accordance with medical ethics; and

RESOLVED, that this resolution be introduced at the next annual meeting of the Medical Association of Georgia, for transmission to the American Medical Association.

REFERENCE COMMITTEE RECOMMENDATION—Your reference committee recommends approval of the resolution introduced by the DeKalb County Medical Society with an additional recommendation that lines 22-24 be changed to read:

"RESOLVED, that this resolution be adopted by the Medical Association of Georgia for transmission and introduction as a resolution to the House of Delegates of the American Medical Association."

HOUSE OF DELEGATES ACTION—Adopted the report of the reference committee as presented.

Chairman Lumpkin then stated that he wished to thank the members of Reference Committee No. 1 for their time and effort.

Dr. Lumpkin reported that this concluded the Report of Reference Committee No. 1, and moved for adoption of his report as a whole. This motion was duly seconded and approved.

Report of Reference Committee No. 2

H. G. Davis, Jr., M.D., Chairman

(The following reports as presented to this reference committee are printed in full with the reference committee's recommendation and the action pursuant to them taken by the House of Delegates.)

Chairman Davis reported to the House that reports and resolutions referred to Reference Committee No. 2 were considered by the committee which met at 9:00 a.m., in the St. Andrews Room of the Savannah Inn and Country Club, Savannah, on May 6, 1969. Members of the committee present were: H. G. Davis, Jr., Sylvester, Chairman; Rupert H. Bramblett, Cumming, Vice-Chairman; Edwin C. Evans, Atlanta; H. Hilt Hammett, LaGrange; C. S. Britt, Brunswick; and William D. Logan, Atlanta.



H. G. Davis, Jr., M.D., of Sylvester, heads Reference Committee No. 2.

President

CHARLES R. ANDREWS, JR., M.D., *Canton*

Most sincerely it is wished to emphasize what an honor and a privilege it has been to hold the office of President of the Medical Association of Georgia for 1968-69. Many thanks are humbly given to all Medical Association of Georgia members for their confidence in having designated me for this position. We have had an active and most interesting year. Within the past 20 years there has never been an annual administration of the Medical Association of Georgia not fraught with problems and advances. With pride this report is hereby presented.

It was indicated last year in the incoming president's report that emphasis would be placed on the strengthening of our basic organization. This premise has been implemented well but leaving ample room for improvement, plus a challenge to continue advancement in all aspects of our organization.

Your president has attended all meetings of the administrative Council; presided at all meetings of the Executive Committee; attended both meetings of the American Medical Association (and actively participated with the Georgia delegation); three meetings of the Organization of State Medical Association Presidents; the Political Action Committee Conference; the American Medical Association-sponsored County Society Conference; and many other local, area, State and national committees, conferences and meetings, including our Medical Education Conference.

Teamwork is the background and the backbone of our organization and it is not a personal claim when you are presented with many "firsts" which have been achieved this year. I bow to the chairmen and committees which have made them possible. Because of their efforts you should have a feeling of pride in your Medical Association of Georgia, as I do in reporting the "firsts" developed by your organization this year:

- (1) The Committee Conclave
- (2) Committee Chairman's Conference
- (3) County society executives' dinner
- (4) Conference of review committees
- (5) Improved Annual Session format
 - (a) County Society Officers' Conference at Annual Session
 - (b) cooperation of all specialties in two outstanding sessions
 - (c) co-hotel arrangement joined by chartered shuttle buses
 - (d) the "Medical Mile," encouraging good health
 - (e) multiple celebrity speakers such as president and past presidents of American Medical Association
 - (f) extra day
 - (g) professional entertainment

My thanks to Dr. Ellington, his committee, and the Georgia Medical Society coordinators.

- (6) Concentrated effort toward closer working relationships with SAMA
- (7) Initiation of special officer mailing "What's Happening" with dates of events
- (8) New building addition started—first building project in history of the Medical Association of Georgia

- (9) Complete monthly membership reports issued to officers, insurance carriers, etc.
- (10) Clarification of "Life Membership"
- (11) Drafting of "Candidate Membership"
- (12) Central billing
- (13) New committees
 - (a) building committee
 - (b) areawide health planning
 - (c) awards

It is most heartening that these have occurred during the 1968-69 year. In making this record possible my sincere appreciation is extended to many: the Executive Committee; Council, our excellent Council Chairman, Dr. Eldridge, and every member of Council; Mr. Edwin Smith, our most capable executive secretary, and our entire headquarters' office staff; our secretary, Dr. Haverty, for the many duties he has performed, and his Medical Education Committee; all of the other chairmen and committee members—each one very important; and the House of Delegates, including every member. Thanks for their interest, time expended, and their direction in the operation of the Medical Association of Georgia, which is becoming nationally recognized as one of the outstanding State organizations.

RECOMMENDATIONS

(1) Expand Central Billing based on the excellent experience gained this year. The Medical Association of Georgia should be designated to collect dues for county, district, MAG, AMA, and PAC—but not mandatory for counties wishing to collect their own.

(2) Continue the Committee Conclave. It was well received this year and will strengthen the organization by improving committee action. Continue the biennial Conference on Medical Education.

(3) Take serious consideration of increased dues. The time has come when the "hard look" recommended two years ago has become a reality. Improved facilities for services to the membership are needed—additional personnel and equipment, benefits such as training opportunities, and supplemental education. A second field man is a recognized need. Also an accounting clerk, additional secretary and possibly a maintenance man or parking attendant are needed. In addition there are building expenses.

(4) Continue to improve relations with SAMA.

(5) Improve the utilization of deputy district councilors.

(6) Encourage future presidents to have closer contact with component societies and districts than I have accomplished.

(7) Encourage closer liaison between MAG and the organized dental profession in Georgia.

REFERENCE COMMITTEE RECOMMENDATION—Your reference committee recommends approval of the report of the president and all its recommendations, with commendation.

HOUSE OF DELEGATES ACTION—Adopted the reference committee recommendation as presented.

President-Elect

JOHN KIRK TRAIN, M.D., *Savannah*

As president-elect of the Medical Association of Georgia for the past year, it has been my duty and

privilege to attend the quarterly Council meetings and the monthly Executive Committee meetings. With the exception of the June meetings which I was forced to miss and one special Executive Committee meeting, I have been present at the discussions at all other meetings. It continues to amaze me how much business comes before these sessions and the dispatch with which it is handled in most cases.

As president-elect and also as an alternate delegate to the American Medical Association, I attended the Annual Meeting of the American Medical Association in San Francisco in June and the Clinical Meeting of the American Medical Association in Miami Beach in December. Too much cannot be said for the workings of our earnest delegation, which as an alternate delegate I have been privileged to observe for the past several years. A friend of mine in a neighboring State told me recently that he did not attend the AMA meetings because as an alternate delegate he felt like a fifth wheel. Our delegation, led by Dr. Chambers, does not permit this feeling to come to our alternate delegates. The alternate delegates and other interested members of the Medical Association of Georgia who attend the AMA meetings are asked to attend reference committee hearings and report to the delegation the activities during these hearings. Their advice and opinions are constantly sought and heeded.

RECOMMENDATIONS

I also attended the Committee Conclave in Atlanta in August and the biennial Conference on Medical Education in February. I feel that both of these meetings should be continued. The Committee Conclave meeting is scheduled for July of this year.

A glance at the budget which has been approved by the Council and passed on to the House of Delegates for final approval shows that proposed expenses for the year 1969 are greater than the expected income. To overcome this, Council has recommended an assessment of each member of the Medical Association of Georgia and it is hoped that the House of Delegates will approve this. As many of the increased expenses in the 1969 budget represent extended activity of the Medical Association of Georgia, it is hoped that some means will be found so that future budgets will not have to be curtailed. With the additions to the present MAG Headquarters building becoming a reality and certain incomes from the leasing of this space coming into our coffers, this may very well take up some of the slack. If this income does not take up all the slack, then certainly a dues raise is indicated.

Stretching as it does "from the Chattahoochee to Savannah and from the mountains to the sea," Georgia is a large State. The Medical Association of Georgia now has one field service representative to cover the 159 counties and 80 medical societies which form the body of the MAG. In order that there might be closer contact between the MAG headquarters and the component societies throughout the State, I feel that we should have a second field service representative. All members of the Medical Association of Georgia could thus be well informed as to the activities of its State Society, the American Medical Association, and the multi-tentacled laws and regulations which are reaching out for us more and more every day from the Federal government.

REFERENCE COMMITTEE RECOMMENDATION—
Your reference committee recommends approval of the report of the president-elect with commendation.

HOUSE OF DELEGATES ACTION—Adopted the reference committee recommendation as presented.

Treasurer

JOHN S. ATWATER, M.D., *Atlanta*

The report of the auditors, Ernst and Ernst, is attached covering the calendar and fiscal years, running concurrently, ending December 31, 1968. Despite the increase in overhead expenses, there has been a sufficient increase in income to meet our obligations.

The growth position of the Association is well pointed out by a review of the past 16 years of operation. In 1953 our assets totalled \$85,127.50 and in the year ending 1968 our assets were \$384,144.84. During the same period our fund equity (net worth) changed from \$78,176.90 (1953) to an all time high of \$286,227.67 (1968).

During the past three years our audits showed an operating profit (excess income over expenses) as follows: \$13,280.40 (1966), \$23,713.31 (1967), and \$20,052.46 (1968). Our free cash position in those same years was as follows: \$87,520.18 (1966), \$115,955.14 (1967), and \$55,854.91 (1968). However, in 1967 it became necessary to use deficit financing which amounted to the following: \$12,758.75 (1967), and \$26,333.28 (1968). For the current year (1969) our deficit financing is anticipated to be \$75,545.00.

The Association ends the year of 1968 still in a sound financial position. Yet, the treasurer would like to point out that future expectations cannot continue this well unless the Association, through the action of the House of Delegates, takes appropriate steps to raise further monies. Without this, our expenses will exceed our income greatly and the Association will be in a precarious and unsound financial position.

The treasurer, on behalf of the Association, would like to express deep appreciation to all those who have had a part in the conduct of this office, especially to our efficient and loyal bookkeeper, Miss Thelma Franklin.

Chairman of the Council
The Medical Association of Georgia
Atlanta, Georgia

We have examined the statement of assets and liabilities of the funds of The Medical Association of Georgia as of December 31, 1968, and the related statements of income and expenses and fund equities for the year then ended. Our examination was made in accordance with generally accepted auditing standards, and accordingly included such tests of the accounting records and such other auditing procedures as we considered necessary in the circumstances. While it was not practicable to confirm the amount due from the United States Government with respect to the balance due under the Medicare contract, we have satisfied ourselves as to this balance by means of other auditing procedures.

In our opinion, the accompanying statement of assets and liabilities and the statements of income and expenses and fund equities present fairly the financial position of the funds of The Medical Association of Georgia at December 31, 1968, and the results of their operations for the year then ended, in conformity with generally accepted accounting principles applied on a basis consistent with that of the preceding year.

Ernst + Ernst

Atlanta, Georgia
March 4, 1969

STATEMENT OF ASSETS AND LIABILITIES—BY FUNDS

THE MEDICAL SOCIETY OF GEORGIA

December 31, 1968

ASSETS

GENERAL FUND

Cash:			
Demand deposits		\$12,597.12	
Savings deposits:			
Restricted	\$18,650.00		
Unrestricted	90,000.00	108,650.00	\$121,247.12
Accounts receivable:			
Advertisers of The Journal		\$ 2,148.08	
Due from National Cancer Institute		5,549.08	
Excess of claim expenses incurred over claim fees received—			
United States Government—Medicare		42,440.30	50,137.46
Other assets			1,037.50
Property and equipment—on the basis of cost—Note A:			
Buildings	\$ 90,954.72		
Furniture and equipment	26,572.22		
	\$117,526.94		
Less allowances for depreciation	69,293.99		
	\$ 48,232.95		
Construction in progress—Note A	83,489.81		
Land	80,000.00	211,722.76	
		<u>\$384,144.84</u>	

ABNER W. CALHOUN LECTURESHIP FUND

Cash	\$ 132.96		
Corporation stocks (quoted market prices \$4,024.00)—at cost ..	5,897.03	6,029.99	
		<u>\$390,174.83</u>	

LIABILITIES AND EQUITIES

GENERAL FUND

Liabilities:			
7½ % construction loan payable—Note A		\$ 72,964.81	
Excess of fees received over expenses—Georgia Regional			
Medical Program		1,837.36	
Advances from Georgia Chapter—American Cancer Society ..		6,000.00	
Advance collections:			
1969 membership dues	\$ 14,765.00		
1969 exhibit space payments	2,350.00	17,115.00	
Fund equity:			
Restricted:			
Regular operating purposes	\$ 20,000.00		
Lecture expenses	786.94		
	\$ 20,786.94		
Unrestricted	265,440.73	286,227.67	
		<u>\$384,144.84</u>	

ABNER W. CALHOUN LECTURESHIP FUND EQUITY

6,029.99
\$390,174.83

Commitment—Note A.
 See Notes to Financial Statements.

STATEMENT OF FUND EQUITIES
THE MEDICAL ASSOCIATION OF GEORGIA

Year ended December 31, 1968

	<i>Balance Jan. 1, 1968</i>	<i>Excess of Income Over Expenses</i>	<i>Fund Transfers</i>	<i>Balance Dec. 31, 1968</i>
GENERAL FUND				
Restricted for operating purposes	\$ 20,000.00	\$ -0-	\$ -0-	\$ 20,000.00
Restricted for lecture expenses	565.49	-0-	221.45	786.94
Unrestricted	245,388.27	20,052.46	-0-	265,440.73
	<u>\$265,953.76</u>	<u>\$20,052.46</u>	<u>\$221.45</u>	<u>\$286,227.67</u>
ABNER W. CALHOUN LECTURESHIP FUND	6,027.49	223.95	221.45*	6,029.99
TOTAL	<u>\$271,981.25</u>	<u>\$20,276.41</u>	<u>\$ -0-</u>	<u>\$292,257.66</u>

* Indicates red figure.

See Notes to Financial Statements.

STATEMENT OF INCOME AND EXPENSES—BY FUNDS

THE MEDICAL ASSOCIATION OF GEORGIA

Year ended December 31, 1968

INCOME	<i>General Fund</i>	<i>Abner W. Calhoun Lectureship Fund</i>
Medical Association of Georgia dues	\$123,600.00	\$ -0-
Advertising—The Journal	49,415.60	-0-
Subscriptions—The Journal	1,763.60	-0-
Exhibitors fees—1968 annual meeting	7,825.00	-0-
Interest income	6,521.39	-0-
Dividends—corporate stocks	-0-	261.92
American Medical Association refund	2,148.85	-0-
Miscellaneous	59.15	-0-
TOTAL INCOME	<u>\$191,333.59</u>	<u>\$261.92</u>
EXPENSES		
Fixed allotments	\$ 18,057.34	\$ -0-
Association office	125,400.73	-0-
Association boards	17,019.84	-0-
Related Association activities	2,919.33	-0-
Contingent fund	8,090.94	-0-
The Journal	46,593.34	-0-
Trustees fees and expenses	-0-	37.97
Recovered expenses	46,800.39*	-0-
TOTAL EXPENSES	<u>\$171,281.13</u>	<u>\$ 37.97</u>
EXCESS OF INCOME OVER EXPENSES	<u>\$ 20,052.46</u>	<u>\$223.95</u>

* Indicates red figure.

See Notes to Financial Statements.

REFERENCE COMMITTEE RECOMMENDATION—
Your reference committee recommends approval of the report of the treasurer with commendation.

HOUSE OF DELEGATES ACTION—Adopted the reference committee recommendation as presented.

Cobb County Medical Society Councilor

W. C. MITCHELL, M.D., *Smyrna*

The Cobb County Medical Society has had another busy year, with the membership again increasing over 10 per cent. The society now has 140 active members, five dues-exempt members, one honorary (disabled) member, two members recalled into service, and two in residency training.

The vice-councilor, Dr. Remer Clark of Marietta, has been of great assistance this year. He has attended all Council meetings, including the one I was forced to miss due to a personal encounter with the Hong Kong Flu. Between the two of us we have given the society a report of Council's activities and have made every effort to represent Cobb County in every Council meeting.

The society has met regularly, with speakers on each occasion. Most of our speakers this year have been either State or nationally recognized medical leaders. One meeting each year is with our legal friends and one meeting each year is with our good ministers.

For several years now the Cobb County Medical Society, along with the lawyers and ministers and now with the assistance of Kennesaw Junior College, has held a symposium on a subject that would be of mutual concern. The general public has been invited. These symposia have created much interest and many thought-provoking conversations. The one this year was on "The Progress of Man Toward the Year 2000." Most of the symposium was held at Kennesaw Junior College with a wrap-up dinner at the Lockheed Dining Room. Six speakers, all well-known nationwide, participated in these discussions. This SYMPOSIUM '69 was designed for the greater Atlanta area and registration was above expectation.

The councilor has enjoyed the Council meetings, missing only one this past year, this being the only meeting missed since he has been connected with Coun-

cil in any way during the past seven years. I consider it a privilege to represent the Cobb County Medical Society.

RECOMMENDATION

The recommendation that I would like to voice at this time is that the state medical association place more emphasis on public relations, perhaps a full-time man for this and this alone. Let's do a little positive thinking and selling—let's sell medicine and Georgia doctors. We know and believe in our product, so let's let the public in on our secret.

SEVENTH DISTRICT MEMBERSHIP

Counties and Secretaries	Members December 31, 1968		Members December 31, 1967	
	MAG	AMA Dues Paying Only	MAG	AMA Dues Paying Only
Cobb				
W. T. Williams				
Marietta	140	135	125	119

REFERENCE COMMITTEE RECOMMENDATION—
Your reference committee recommends that this report be approved after deletion of the following: Page 2, beginning on line 3, delete the comma, and the words "perhaps a full-time man for this and this alone," so that the recommendation reads as follows: "The recommendation that I would like to voice at this time is that the state medical association place more emphasis on public relations." Mr. Speaker, your committee recommends this deletion since the matter of additional MAG staff is considered in connection with a later report.

HOUSE OF DELEGATES ACTION—Adopted the reference committee recommendation as presented.

Fulton County Medical Society Councilor

FLEMING L. JOLLEY, M.D., *Atlanta*

Fulton County Medical Society has been represented at all Council meetings by its councilors or vice-councilors.

RECOMMENDATION

The magnitude of government-related policies has increased during the past years and it would seem that further consideration to the need of an "ombudsman" by the Medical Association of Georgia should be made.

One recent problem has confronted the Fulton County Medical Society. This has been a number of inquiries related to paramedical schools.

RECOMMENDATION

It is recommended that the Medical Association of Georgia appoint a committee for establishing minimal requirements for accreditation of the curricula of these schools.

REFERENCE COMMITTEE RECOMMENDATION—
Your reference committee recommends that this report as a whole be approved with the following changes in the recommendations contained in the report: In line 12, after the word "the" insert the words "Executive Committee of" and in line 13, after



Contestants for the Medical Mile gather on the lawn in front of the Savannah Inn and Country Club.

the word "committee" delete the words "for establishing" and insert the words "to study the establishing of," so that the recommendation would read: "It is recommended that the Executive Committee of the Medical Association of Georgia appoint a committee to study the establishing of minimal requirements for accreditation of the curricula of these schools."

With regard to the recommendation that consideration be given to the need for hiring an "ombudsman," which the dictionary defines as a go-between acting for the common man, your reference committee wishes to bring to the attention of the speaker and the House of Delegates that mention of additional MAG staff was included in the Report of the President who recommended a second field service representative; the Report of the Cobb County Councilor who recommended a full-time person for public relations; the Report of the Committee on Medical Education which recommended a second Field Service Representative for Continuing Education; the Report of the President-Elect which mentioned that we should have a second field-service representative, and the Report of the Committee on Special Finance of Council which mentions the need for several additional employees in the future. Since all of these reports seem to recognize a similar need for additional people, but for very different reasons and to accomplish different goals, your reference committee recommends that the entire matter of additional personnel be referred to the Executive Committee of Council for more detailed study.

HOUSE OF DELEGATES ACTION—Speaker Rogers recognized Delegate F. William Dowda, who moved that the recommendation of the reference committee be further amended by inserting the words "and implementation" after the word "establishing" which would then make the recommendation read, "it is recommended that the Executive Committee of the Medical Association of Georgia appoint a committee to study the establishing and implementation of

minimal requirements for accreditation of the curricula of these schools." Dr. Dowda's motion was approved. The House then adopted the reference committee recommendation as amended.

Richmond County Medical Society Councilor

HARRY D. PINSON, M.D., *Augusta*

After having served as MAG Councilor for Richmond County Medical Society for the past eight years, I am now leaving office effective with the 1969 Annual Session.

I wish to express my regrets at having to leave this organization and wish to thank all of the officers of the Medical Association of Georgia for the privilege of having worked with them.

My only recommendation at this time is to challenge both the House of Delegates and Council to be more aware of the financial problems of the Association and for more fiscal responsibility.

TENTH DISTRICT MEMBERSHIP

Counties and Secretaries	Members December 31, 1968		Members December 31, 1967	
	MAG	AMA Dues Paying Only	MAG	AMA Dues Paying Only
Richmond				
C. S. Mulherin				
Augusta	280	250	272	246

REFERENCE COMMITTEE RECOMMENDATION—Your reference committee recommends approval of the report of the Richmond County Medical Society Councilor with commendation.

HOUSE OF DELEGATES ACTION—Adopted the reference committee recommendation as presented.

Finance

C. E. BOHLER, M.D., *Chairman*

Your Committee on Finance met on November 17, 1968, for the purpose of proposing the Association's budget for the 1969 calendar year. The committee made an exhaustive study of sources of income and of scheduled and anticipated expenditures. The proposed budget was subsequently presented to Council and was approved as published with this report.

You will note that a deficit of \$75,000 has been budgeted for the 1969 calendar year. It is anticipated that \$40,000 will be recovered from the Federal government as reimbursable expenses, and accordingly has been deducted under "Association Office Expenses." The government contracts administered by MAG do not provide for a fixed percentage of expenses that may be recoverable.

It should be pointed out that recovery of the anticipated \$40,000 will not reduce the \$75,000 deficit cited above.

It is also apparent that architects' fees and expenses in the amount of \$45,000 must be approved and added to the operating deficit. One \$10,000 payment from 1968 reserves has been made toward the \$55,000 architects' total fee.

The following is a summary of the reasons for the budget increases in 1969:



Winner of the Medical Mile—Richard L. Benson, M.D., of Douglas.

- (1) Increase in size of MAG building
 - (a) building mortgage and interest payments
 - (b) building taxes
 - (c) building depreciation on new building
 - (d) building insurance
 - (e) building janitorial services, utilities
- (2) Increase in allotment to Woman's Auxiliary, directed by House
- (3) Increase in attorney's fees because of suit vs. osteopaths—Council directed
- (4) Donation to Allied Health Careers, Inc., directed by Council
- (5) Cost of Medical Education meeting (biennial) directed by House
- (6) Increase in postage and other office supplies, because of House-directed central billing
- (7) Some increase in travel expenses and MAG meeting costs
- (8) Increase in costs of the House-directed charge of the Annual Session
- (9) Slight increase in Traffic Safety allotment
- (10) Retaining an actuary for the Insurance and Economics Committee
- (11) "Campaign expenses" for Frank Walker in New York City
- (12) Decrease in *Journal* income
- (13) Paying for president-elect's travel and per diem to AMA meetings
- (14) Attempt to equalize retirement benefits for two loyal and dedicated MAG staff members
- (15) Salary increases

As has been previously discussed, we have paid the mortgage on the existing building. Due to the building expansion, we have placed a new mortgage of \$551,000 on the land and building, payable \$54,255 annually (including interest) for 19 years. The budget for the current year includes \$47,547 representing interest during the construction phase, and principal and interest payments for the remainder of the year.

SUMMARY-COMPARISON OF BUDGETED AND ACTUAL OPERATIONS

THE MEDICAL ASSOCIATION OF GEORGIA Period January 1, 1968 to November 30, 1968

	1968 Budget	Actual Jan. 1-Nov. 30, '68	(Over) Under Budget	1969 Proposed Budget
INCOME				
I. (a) MAG Dues	\$123,000.00	\$123,600.00	\$ (600.00)	\$125,000.00
(b) Int. & AMA	8,500.00	8,064.00	436.00	4,175.00
(c) GP Service	3,250.00	3,250.00		3,250.00
II. ANNUAL SESSION	7,875.00	7,900.00	(25.00)	8,400.00
III. JOURNAL	55,000.00	39,720.19	15,279.81	51,000.00
IV. CONTINGENT				
Transf. from Opr. Cap.	10,000.00	10,000.00		
Transf. from Opr. Cap.—Expansion	10,000.00	10,000.00		
	<u>\$217,625.00</u>	<u>\$202,534.19</u>	<u>\$15,090.81</u>	<u>\$191,825.00</u>
EXPENSES				
I. (a) Fixed Allotments	\$ 22,280.80	\$ 18,604.95	\$ 3,675.85	\$ 71,895.00
(b) Assoc. Office	128,961.88	109,599.74	19,362.14	112,370.00
(c) Assoc. Committees	22,980.00	16,609.77	6,370.23	31,375.00
(d) Rel. MAG Activities	1,525.00	1,502.25	22.75	3,525.00
(e) Contingent-Ex. Com. Dis. Fd. Trans. from				500.00
Opr. Cap.	10,000.00	9,119.35	880.65	
Trans. from Opr. Cap.—Expansion	10,000.00	10,000.00		
II. JOURNAL	48,210.60	43,369.60	4,841.00	47,705.00
	<u>\$243,958.28</u>	<u>\$208,805.66</u>	<u>\$35,152.62</u>	<u>\$267,370.00</u>
Deficit	<u>\$ 26,333.28</u>			<u>\$ 75,545.00</u>
LIQUID FUNDS AVAILABLE				
I. C & S Checking		\$ 4,079.79		
C & S Certificates		20,000.00		
II. Fulton Federal Savings & Loan		10,000.00		
Peachtree Federal		6,000.00		
(Depreciation Savings Accounts)				
III. Savings Accounts				
Atlanta Federal Savings		5,000.00		
C & S National Bank		30,000.00		
Decatur Federal		40,000.00		

BUDGETED AND ACTUAL OPERATIONS

	1968 Budget	Actual Jan. 1-Nov. 30, '68	(Over) Under Budget	1969 Proposed Budget
I. (a) FIXED ALLOTMENTS				
Payment on Mortgage	\$ 3,000.00	\$ 3,000.00		
Interest on Mortgage	150.00	87.92	\$ 62.08	\$ 37,547.00
MAG Atty. Expenses	300.00	226.35	73.65	4,300.00
MAG Atty. Retainer	4,800.00	3,600.00	1,200.00	4,800.00
Pension Payments	1,800.00	500.00	1,300.00	600.00
Pres. Honorarium	2,400.00	2,400.00		2,400.00
Annual Audit	1,500.00	1,500.00		1,800.00
Taxes	4,100.00	4,335.02	(235.02)	4,500.00
Retirement Cont.	3,780.80	2,565.41	1,215.39	13,248.00
Retirement Trust. Fee	150.00	90.25	59.75	200.00
Woman's Auxiliary	300.00	300.00		2,500.00
	<u>\$ 22,280.80</u>	<u>\$ 18,604.95</u>	<u>\$ 3,675.85</u>	<u>\$ 71,895.00</u>
(b) ASSOCIATION OFFICE				
Salaries	\$ 86,120.00	\$ 77,622.57	\$ 8,497.43	\$ 92,800.00
Ins. & Bonds	2,950.00	2,806.41	143.59	3,500.00
Payroll Tax	3,551.88	2,770.02	781.86	3,000.00
Travel-President	1,500.00	1,251.91	248.09	1,500.00
Travel-President-Elect				1,000.00
Travel-Office	4,500.00	4,228.31	271.69	5,000.00
Travel-Del., Sec. AMA—Annual & Clinical	4,500.00	2,645.18	1,854.82	4,600.00
Travel-Alt. Del.	3,420.00	1,995.84	1,424.16	3,800.00
Maint. & Repairs				
Building	750.00	532.13	217.87	750.00
Equipment	600.00	256.14	343.86	600.00
Tel. & Tel	4,500.00	2,522.46	1,977.54	4,000.00
Depreciation				
Building	2,000.00		2,000.00	8,100.00
Equipment	650.00		650.00	650.00
Postage	3,500.00	3,298.71	201.29	4,500.00
Office Supplies	3,500.00	3,572.04	(72.04)	4,800.00
Jan. Serv. & Supplies	2,620.00	2,384.50	235.50	5,500.00
Meetings	600.00	803.32	(203.32)	1,500.00
Dues & Sub.	400.00	330.00	70.00	470.00
Heat, Light & Water	3,000.00	2,486.69	513.31	6,000.00
Sundry	300.00	93.51	206.49	300.00
	<u>\$128,961.88</u>	<u>\$109,599.74</u>	<u>\$19,362.14</u>	<u>\$152,370.00</u>
Reimbursed Expenses				<u>\$ 40,000.00</u>
				<u>\$112,370.00</u>
(c) ASSOCIATION COMMITTEES				
<i>Standing</i>				
Annual Session	\$ 8,730.00	\$ 7,758.91	\$ 971.09	\$ 12,550.00
Professional Conduct	50.00		50.00	50.00
Traffic Safety	1,150.00	580.89	569.11	1,500.00
<i>Special</i>				
Allied Health Careers				5,500.00
AMA-ERF	225.00	225.00		
Blood Banks	25.00	25.00		25.00
Cancer	25.00		25.00	50.00
Crippled Children	50.00		50.00	
Disaster Medical Care	100.00	98.89	1.11	50.00
Headquarters Expansion	50.00		50.00	
Hospital Activities	200.00	200.00		200.00
Insurance & Economics	200.00	200.00		800.00
Legislation	2,500.00	2,364.90	135.10	2,700.00
Mat. & Inf. Welfare	450.00	94.10	355.90	450.00
Medical Education	400.00	397.94	2.06	1,600.00
Medical Review & Nego.	50.00		50.00	300.00
Medicine and Religion	250.00	28.16	221.84	

	1968 Budget	Actual Jan. 1-Nov. 30, '68	(Over) Under Budget	1969 Proposed Budget
Mental Health	50.00		50.00	200.00
Nursing Liaison	50.00	4.25	45.75	50.00
Occupational Health	300.00		300.00	
Paramedical Study	1,500.00	109.00	1,391.00	
Public Service	2,050.00	1,442.56	607.44	1,250.00
Rural Health	1,175.00	449.15	725.85	1,000.00
School Child Health	1,500.00	1,131.02	368.98	1,500.00
Separate Billing	50.00		50.00	50.00
Special Activities	50.00		50.00	
Voluntary Health Agencies	300.00		300.00	
Contribution to GaMPAC	1,500.00	1,500.00		1,500.00
MAG Liaison Comm. with Board of Med. Examiners				50.00
	<u>\$ 22,980.00</u>	<u>\$ 16,609.77</u>	<u>\$ 6,370.23</u>	<u>\$ 31,375.00</u>
(d) RELATED MAG ACTIVITIES				
AMA Delegates Meeting	\$ 800.00	\$ 800.00		\$ 2,800.00
Interprofessional Council	125.00	125.00		125.00
SAMA	500.00	500.00		500.00
SMEB	100.00	77.25	22.75	100.00
	<u>\$ 1,525.00</u>	<u>\$ 1,502.25</u>	<u>\$ 22.75</u>	<u>\$ 3,525.00</u>
(e) CONTINGENT				
Trans. from Opr. Cap.	\$ 10,000.00			
MAG Equipment		\$ 561.35		
Medicare Equipment		753.53		
SAMA		300.00		
SAMA Dues		100.00		
Health Careers Dues		25.00		
Travel-Wash. (JWC)		148.33		
Ex. Com. Dis. Fd. (Ins. & Ec.)		100.00		\$ 500.00
Ex. Com. Dis. Fd. (Comm. Conclave) ..		88.78		
Hardman Award		185.89		
GaMPAC		1,500.00		
AMA-ERF20		
Hospital Activities		14.05		
AMA Del. Meetings		157.91		
Atty.-Osteo.		4,748.00		
Ct. So. Exec. Dinn. Com. Conclave		95.00		
Parking		172.80		
Delegates Caucus		15.06		
Continued Education		153.45		
	<u>\$ 10,000.00</u>	<u>\$ 9,119.35</u>	<u>\$ 880.65</u>	<u>\$ 500.00</u>
(f) TRANSF. FROM OPR. CAP. BUILDING EXPANSION				
	\$ 10,000.00	\$ 10,000.00		

II. JOURNAL

Printing	\$ 35,000.00	\$ 31,069.75	\$ 3,930.25	\$ 34,000.00
Salaries	9,000.00	8,454.34	545.66	8,800.00
Insurance	250.00	260.69	(10.69)	255.00
Payroll Tax	630.60	442.53	188.07	475.00
Engraving & Cuts	1,900.00	2,159.71	(259.71)	2,300.00
Postage	1,000.00	762.46	237.54	1,000.00
Stationery	100.00		100.00	100.00
Clipping Service	180.00	151.36	28.64	180.00
Add. & Supplies	100.00	45.38	54.62	125.00
Sundry	50.00	23.38	26.62	200.00
SJAB Meeting				270.00
	<u>\$ 48,210.60</u>	<u>\$ 43,469.60</u>	<u>\$ 4,841.00</u>	<u>\$ 47,705.00</u>

REFERENCE COMMITTEE RECOMMENDATION—Your reference committee recommends approval of the Report of the Committee on Finance with commendation, and with the following additional recommendation which was brought out in the committee hearings and seemed to have special merit: We recommend that expenses of the immediate past president of MAG be paid for attendance at the AMA Annual and Clinical meetings. Your reference committee makes this recommendation because of the obvious benefits to MAG of having this officer with our delegation. We feel that during his two previous years he will have made important contacts and that these contacts should be beneficial to our delegation.

HOUSE OF DELEGATES ACTION—Adopted the reference committee recommendation as presented.

Insurance and Economics

WILLIAM W. MOORE, M.D., *Chairman*

The committee has met on four occasions in September and November, 1968, and January and March, 1969. Between and since those meetings, a considerable amount of correspondence and telephone activity has continued regarding the business of the committee. The committee would like to express its appreciation for the efficiency and energy of our executive secretary, Mr. Ed Smith.

The following specific problems have been considered and dealt with as indicated:

An MAG-sponsored group plan of catastrophic liability coverage, generally referred to by the term "umbrella," was instituted through the firm of Crum and Forster, available through any of its large panel of accredited agents widely dispersed throughout the State. It is an adjunct to our group professional liability plan through St. Paul.

A further definition of the jurisdiction of the Committee on Insurance and Economics was established, with the understanding that questions regarding fees and/or utilization problems from all insurance programs would be referred to the Medical Review and Negotiating Committee. The Insurance and Economics Committee would retain jurisdiction of those plans of insurance sponsored by MAG and the investigation of any additional insurance programs which might be appropriately sponsored by MAG.

The Life of Georgia insurance programs relating to Life, Accidental, Death and Dismemberment, Disability Income and Major Hospital and Nursing Plans were reviewed. It is noted that we are continuing to experience a decline in participation in all aspects of the plan. This, of course, poses a serious threat to any sort of group plan since its feasibility is primarily predicated on a substantial participation by the membership of any covered group. The problem usually becomes a vicious cycle, with declining participation producing increasingly unfavorable experience requiring increasing rates, which in turn make the program even more unattractive to better participation. We find ourselves in just such a vicious cycle at this time, and through meetings with representatives of Life of Georgia, have attempted to alter the situation by (1) redrafting a new member "Welcome Letter" including reference to MAG's insurance programs and the advantage to be obtained by use of those plans; (2) ef-

forts to change the constitution and bylaws of MAG to allow medical students membership, which would serve the combined purpose of offering an insurance program to medical students not currently available at these prices and at the same time strengthening the MAG program by the inclusion of a low-risk group; (3) instituting the practice of writing all physicians who have dropped their Life of Georgia coverage in an effort to learn how we might have prevented that action; (4) speeding up our process of notifying the company of new membership approvals, and (5) distributing to every member of the Association an annual report on membership plans, thereby bringing to the attention of the members not presently covered the availability of these plans.

In addition, we have requested that group agents and supervisors from Life of Georgia accentuate their enlistment program in their local areas when new physicians open practice. Life of Georgia has also agreed to study the inclusion of additional features such as an option for an additional \$10,000 of life insurance, or reduction in deductible amounts which might make the various programs more attractive, especially to the older members.

Because of the complexities and varieties of insurance programs sponsored by the Association, and because of their magnitude of financial importance, the committee felt the need to have professional assistance in the carrying out of its function and arranged to retain Mr. John Glenn as an actuarial consultant to the committee.

RECOMMENDATION

Our experiences throughout the year have convinced us that this was a wise move and the committee strongly recommends the continuation of this relationship.

Some problems concerning "cancer" insurance programs have been brought to the committee, involving limitations of coverage in circumstances where pathological diagnosis is not feasible or where it would not constitute good medical practice. Another situation, where such a policy considered the human skin as a single organ and denied coverage for more than one lesion despite the fact that they were widely separated both in time and distance, has been discussed and correspondence is in progress with the involved company, in an effort to bring about an appropriate change.

Efforts are now underway through a representative of the Medical Advisory Board of the Workmen's Compensation Board to seek revision and improvement of the Workmen's Compensation claim forms.

By far, the greatest amount of time spent by the members of the committee dealt with the MAG's basic professional liability plan underwritten by the St. Paul Insurance Company. It seems appropriate and even necessary at this point to include in this report some figures indicating some of the problems involved in professional liability insurance as well as comment on the status of such insurance elsewhere in the country. A number of outstanding cases in the State have increased from 61 in 1963 to 154 at the end of 1968. During the past five-year period, the program showed a rapidly declining profit margin during the years 1964, 1965 and 1966, and a rapidly increasing loss figure for the years 1967 and 1968. Our

own actuary, giving us the benefit of every consideration involving the figures, estimates that the St. Paul Companies have had something less than two per cent profit in the five-year period, which does not create a very favorable climate for continuation of the coverage without proper adjustment. The following factors are considered to be important in the committees forming the opinion that the trend will continue to be unfavorable: (1) the increased use of experimental drugs and surgery; (2) the judicial doctrine requiring disclosure to a much greater degree than in the past which has limited, in many instances, the efficiency of defense; (3) an increased number of suits; (4) a diminishing personal relationship between the patient and the physician, relating substantially to the increased use of specialist referrals where there has been no long or personal contact between the physician and the patient; (5) the increased organization of plaintiff attorneys developing this aspect of legal practice; (6) the increased availability of medical testimony, relating substantially to the fact that medical competency is no longer considered confined to the average of that practiced in a local community. In essence, judicial opinions have been rendered stating that because of the efficiency of modern communication, medical competency is a national rather than a local affair; and (7) an increase in cost of settling nuisance suits.

With this background, the St. Paul representatives have requested and the Insurance Committee has approved an increase in rates for professional liability insurance for the coming year which will compound out to approximately 35 per cent. The St. Paul company has been completely open and all of the figures relevant to this program have been made available in a most cooperative fashion to our actuarial consultant, Mr. John Glenn, who visited the home office for study of the problem. It has been determined, for instance, that the reserve funds set up for the outstanding cases have, on the basis of experience, reflected a particularly acute and accurate acumen for handling this type of problem. St. Paul has also requested that we go to a five-class break down by physician specialty in keeping with the pattern in 48 of the other 50 states. This has been substantiated to date by experience rating and the company has agreed to monitor the experiences by specialty for the State of Georgia so that this information will be available to the committee in the future.

The following tables will indicate the 1968 rates for 100-300,000 coverage (the most common type), the new rates for 1969, the 1969 rates in the State of Virginia and the 1969 rates for the State of California. It is hoped that these figures will afford some solace. We should add that even with the new rate increases, we will have the lowest rates in the nation for Classes 2 and 5 physicians, the fifth lowest rate for Classes 1 and 4 and the sixth lowest rate for Class 3 throughout the nation. In addition to this, we are affording through the MAG group sponsorship the opportunity for a number of our physicians to be covered where they might very well otherwise find considerable difficulty. For instance, certain specialty groups have reflected such poor experience in recent years that if we were not covered as a group, these specialists could not obtain coverage through our present company.

PREMIUM RATES FOR 100,000/300,000 LIABILITY INSURANCE COVERAGE

Classification	1968	1969	1969	1969
	GA.	GA.	VA.	CALIF.
I. Physicians, no surgery . . .	62	78	91	479
II. Physicians, minor surgery	74	93	158	839
III. Surgeons, major surgery .	185	243	272	1,437
IV. Surgeons—Specialists, General, Cardiac, Otolaryngologists (no plastics), Thoracic, urologists, Vascular	206	280	363	2,538
V. Surgeons—Specialists, Anesthesiologists, Ob-Gyn, Plastic Surgeons, Neurosurgeons, Orthopedic Surgeons, Otolaryngologists per- forming plastic surgery . . .	206	290	453	3,176

The subject of the use of a pre-trial medical panel for evaluation of these problems was discussed on two occasions during the year and on both occasions we were requested by the company not to institute such a panel because of the limiting and disabling effect it has on the defense of professional liability claims, principally because of the newer requirements of disclosure.

The Committee on Insurance and Economics was called on during the year by the Committee on Legislation to provide consultation regarding several matters under their consideration. The first matter, House Bill 53, would require insurance contracts written in Georgia to include language to provide for payment of care rendered by an applied psychologist. Another was Senate Bill 24, which would provide that insurance contracts written in Georgia must include language which would provide for reimbursement under the policy to providers of any type of remedial care, such as chiropractors. A third matter of legislation which the committee was called on to consider was Senate Bill 41, which will require, if passed, that insurance contracts must say if psychiatric care is not covered. If it is covered, then the insurance contract must provide for payment for psychiatric care rendered in psychiatric hospitals. Senate Bill 41 also carries an amendment which would provide for payment of care rendered by applied psychologists when that care is prescribed by a doctor of medicine. In all instances where the Committee on Insurance and Economics was requested to consider matters of legislation, the committee made its recommendations to the Committee on Legislation as requested.

The Committee on Insurance and Economics has spent a busy year, and the chairman wishes to express his appreciation by the vehicle of this report to the Executive Committee of MAG for the opportunity of serving this first year as chairman, and to the members of the Committee on Insurance and Economics for their dedication and hard work during this busy year.

REFERENCE COMMITTEE RECOMMENDATION—
Your reference committee recommends approval of the Report of the Committee on Insurance and Economics with commendation.

HOUSE OF DELEGATES ACTION—Adopted the reference committee recommendation as presented.

Medical Education

J. RHODES HAVERTY, M.D., *Chairman*

In 1964, Dr. Tom Goodwin, that leader who has meant so much to Georgia medicine in so many ways, began making plans for a conference of physicians who were concerned about medical education in our State. In his annual report that year he urged that the MAG get behind continuing medical education programs, relating them to local and regional medical society meetings. To its best abilities, your Committee on Medical Education continues to urge this concept.

At a meeting chaired by AMA Past-President Dr. James Z. Apple, held in Chicago in November, 1968, a speaker made an important statement. He said that the medical schools of our nation must look to the future, because basic education is their métier, and it is this basic education that prepares the future physicians for their role in life. But continuing education is the responsibility of the State medical associations since they must look to the present, for each of us has to keep up with the ever-changing, present-day trends in medicine. The MAG is trying to assume this responsibility, utilizing the educators of Georgia and all other resources possible in carrying-out this mandate.

To this end, the Third Biennial Conference on Medical Education was held at Callaway Gardens on February 28, March 1 and 2, of this year. Topics discussed in depth and with great interest included: licensure problems and examination of physicians, continuing medical and allied health education, and training and utilization of allied health personnel. We were most honored to have as resource persons for this conference Dr. John P. Hubbard, President of the National Board of Medical Examiners; Mr. Ralph Kuhli, Director of the Department of Allied Medical Professions and Services of the AMA, and Dr. Darrel J. Mase, Dean of the College of Health-Related Professions of the University of Florida. Besides the exchange of knowledge and opinions among our State's leading medical educators and practicing physicians, much camaraderie prevailed, as was the case with the two preceding conferences. I think the conference was appreciated and enjoyed by all who participated.

Besides the discussion topics, a fascinating panel-discussion by members of the Curriculum Committees of Emory University School of Medicine and the Medical College of Georgia took place. All of us will watch with great interest these innovative changes taking place in our two medical schools within the State of Georgia. Résumés of the topic discussions, as well as of the curriculum changes, appeared in the April 1969 issue of the *Journal*.

Continuing education seemed to dominate the discussions at the conference just mentioned. One method of disseminating current medical knowledge has been the "Circuit Courses" sponsored by the Medical College of Georgia. Response to this has been disappointing, and the courses have been discontinued on a routine basis because of lack of attendance in several parts of our State. The Medical College faculty assures me that courses will be continued, however,

wherever there is a demand and a request made for this service. This leads to a recommendation to this House from your chairman, which is appended to the end of this report, for your convenience.

As Chairman of the Medical Education Committee, I have attended several State and national meetings on medical education during 1968-69, including moderating a panel discussion on the Education of Allied Health Personnel at the AMA Congress on Medical Education in Chicago in February, 1969. Incidentally, it was at this meeting that the AMA announced the creation of a Specialty Board for Family Practice, culminating long study and much work by the AAGP and other medical leaders of this State and throughout the nation. The AMA also plans to confer awards to all those physicians who continue to update their education.

Another item of interest is the bill presently in the General Assembly allowing the licensure of physicians in Georgia by the FLEX Examination. This would test more accurately the competence of a budding practitioner and would allow easier reciprocity for licensure among the States of the Union. At the time this report is being written, in early March, the Bill has passed the House, and has been reported out from a Senate sub-committee with a "do-pass" label.

Increased production of physicians is an important matter. Associate Deans Carter and Ahlquist of the Medical College of Georgia have announced that that institution will increase its entering class size of medical students to approximately 120 in September of this year. They anticipate reaching a class size of 144 within three years. Dean Richardson of the Emory University School of Medicine states that the enrollment of entering classes there will remain at a level of 80 for the immediate future. He comments, however, that the entering junior class at Emory could accommodate almost twice that number. I sincerely hope that increasing numbers of allied health personnel, with which matter I am engaged currently, also will help to alleviate some of our health manpower problems.

May I close with a quotation from Dr. Morton Levitt, Associate Dean of the Wayne State University School of Medicine? He speaks important and prophetic words to medical educators as well as to community leaders.

"Only when we have met our first responsibility to provide the soundest and most stimulating educational environment for our students and faculty (and few of us can currently boast of such an accomplishment) are we justified in trying to undertake the overwhelming task of providing high-quality health care for the community-at-large. There is no question that the medical school's most effective contribution in these days of changing public expectation still lies in its ability to provide models of excellence which can be replicated elsewhere by those community institutions which have the time, resources, and that general responsibility."

RECOMMENDATIONS

I propose and recommend that the MAG staff be increased by one field service person, preferably a physician, to initiate, coordinate, and carry out programs in continuing medical education for the physi-

cians of Georgia. This individual would be expected to identify the desires and needs of the medical community as they pertain to continuing education, and to set about finding ways to implement these goals. He would be expected to work closely with the medical schools, with the GRMP, and with all available resources in accomplishing his functions.

REFERENCE COMMITTEE RECOMMENDATION—Your reference committee recommends approval of the Report of the Committee on Medical Education with the deletion of the recommendation as contained in the sentence beginning on page 3, line 32. The recommendation thus deleted was contained in your reference committee's action on the Report of the Fulton County Medical Society Councilor.

HOUSE OF DELEGATES ACTION—Adopted the reference committee recommendation as presented.

Title XIX

JOSEPH S. WILSON, M.D., *Chairman*

The Special Committee on Title XIX has served since December 1966 as an advisory committee to Council on the Georgia Title XIX Program. This program, which became operative in October 1967 is administered by the Georgia State Department of Health, and provides comprehensive medical care to indigent patients of the State. The program has registered a steady growth in payments for physicians services, and in one recent month more than 26,000 individual claims for physicians services were processed, amounting to more than \$650,000 in payments. The steady growth in physicians claims must represent an increasing utilization of the available services by the needy. Every effort is being made to expedite payment of claims. In the event of unusual delay, the physician is encouraged to consult directly with the Medical Assistance Branch of the Department of Health.

The plan has been operating under principles that we feel promote quality of care and acceptability by both patient and physician. These include a wide variety of covered medical services, freedom of choice of physician, fee for service, and usual and customary charges.



John W. Mauldin, M.D. of Lawrenceville; J. S. Wilson, M.D. of Atlanta; and J. Frank Walker, M.D. of Atlanta relax for a few moments.

It is inevitable that some mistakes and confusion arise. Claims are processed first through an intermediary and forwarded to the Health Department for payment. Disputed claims are referred to medical review committees at the district level. It has been found that most disputed claims are due to lack of information, and cases actually reviewed by the committees are very few.

RECOMMENDATIONS

The involvement of government in medical care is here to stay. We would recommend that a permanent committee on Government Medical Services be established by the Medical Association of Georgia to oversee these programs for organized medicine.

REFERENCE COMMITTEE RECOMMENDATION—Your reference committee recommends approval of the report of the Ad Hoc Committee on Title XIX with commendation.

HOUSE OF DELEGATES ACTION—Adopted the reference committee recommendation as presented.

Medical Review and Negotiating

HENRY S. JENNINGS, M.D., *Chairman*

This committee has continued its activities during the year, receiving excellent cooperation from the dedicated and conscientious members representing the several specialty societies.

A Review Committee Conference was organized and conducted in November, 1968 for the purpose of orientation of the various district (and local) society review chairmen. This conference was well attended and all indications are that it proved to be a worthwhile and instructive occasion for those present. It is felt that this conference has resulted in a better functioning system of local review.

The committee has functioned on several occasions for the purpose of reviewing claims appealed from district or local society review committees.

A sub-committee has been appointed to work with the representatives of the Workmen's Compensation Board toward the development of more adequate compensation for services rendered to those patients covered by such a program.

There are no specific recommendations from this committee requiring action by the House of Delegates, but I wish to thank MAG for the opportunity which has been mine in serving as chairman of this committee.

REFERENCE COMMITTEE RECOMMENDATION—Your reference committee recommends approval of the report of the Committee on Medical Review and Negotiating with commendation.

HOUSE OF DELEGATES ACTION—Adopted the reference committee recommendation as presented.

Special Finance

CHARLES T. COWART, M.D., *Chairman*

A joint meeting of the Medical Association of Georgia Committee on Finance and the Special Finance Committee was held during the Committee Conclave on September 7, 1968.

The two committees acting together agreed on the following:

RECOMMENDATIONS

(1) Increase the annual membership dues to MAG to \$80.

(2) Assess each active member of the MAG \$50 or \$100 per year for five years for the MAG Foundation, the amount of assessment to be determined by the House of Delegates.

The following points were brought out in the discussion:

(1) MAG is in deficit financing already, and expenses are expected to rise now at a greater rate than ever before.

(2) The committees foresee the coming need of additional employees including the probable need for a full-time M.D. to act as coordinator of the various programs, governmental and non-governmental. Our last Executive Secretary pointed out to us the importance of adequate compensation to all personnel for service to MAG. He stated that it is less expensive to raise the present employees than to hire and train new employees. Systematic raises should be budgeted.

(3) The Association is in the process of building and expanding. There is need for money to back up this undertaking and speed up the amortization of loans and expenses.

(4) The MAG is a benevolent organization, but its benevolences have been primarily by individual members. The Association as a whole has reached that stage where it must initiate and finance benevolent community-related projects and acts as well as act as the administrator and coordinator of government planned and financed projects.

(5) The MAG Foundation is that instrument which should place the physicians of Georgia in the position of leadership in the health care industry. To this point, the MAG Foundation has been primarily a brochure. We can never attract significant gifts and bequests to the Foundation until the members have made it fiscally sound and well-funded.

The committees feel that the Trustees of the Foundation should develop specific programs, omitting the generalities. Scholarships, financing public assistance projects, etc., should be worked out in great detail. The Trustees find it difficult to work out anything with an empty treasury.

(6) The committees also recommended that the MAG budget a generous contribution to the MAG Foundation each year. This must be studied and approved by legal counsel.

PERSONAL OBSERVATIONS OF THE CHAIRMAN OF THE COUNCIL SPECIAL COMMITTEE ON FINANCE:

I have now been a member of the Medical Association of Georgia long enough to see the headquarters grow from a one man operation to its present state. The growth has been healthy and satisfying. I am proud of my association, and can truthfully say that it has always risen to the occasion. It is progressive, and has taken the giant steps when the occasions have arisen.

We have concerned ourselves mostly with house-keeping and administration. A revolution has been

underway for the past few years, and I must say that government agencies and social planners have all but taken the leadership from us.

We must broaden our base. We must plan, initiate, and finance community action in the health field. We must regain the leadership that we relinquished to the planners. We must study community needs and their solutions. We may come up with the best solution of all. We are supposed to be experts in providing health care.

To discharge our obligations we must:

(1) Kindle an active interest and participation of every member of the MAG in its affairs. This is the most important thing of all. We should hire as many people as it takes to do this.

(2) Every member should make generous donations to the MAG Foundation and encourage philanthropic individuals, organizations and foundations to do so. Every member should be an agent for promotion of the Foundation.

(3) Give as many members as possible jobs to do, and have the field men keep after them to get the jobs done. They will soon function of their own free will.

(4) The Committee Conclave might well be extended to include a general session of all committees in exploring the community needs and the future course of the Association.

(5) To accomplish our aims and purposes we will need financing on a large scale. We will need planning and study on a large scale. I have never seen MAG fail to live up to its obligations.

Supplemental Report No. 2

MEMBERSHIP ASSESSMENT

F. G. ELDRIDGE, M.D., *Chairman of Council*

WHEREAS, the following motion was adopted by the MAG Council at its meeting on May 3, 1969:

"Council recommends to the House of Delegates that an assessment of \$50 for the fiscal years 1969 and 1979 be approved; that during this period of time a study should be made for the need of a dues increase in 1971; and also recommends that no additional assessment for the MAG Foundation be made at this time." And

WHEREAS, the budget and finances of the Medical Association of Georgia will be inadequate to meet the needs of building expansion, which was approved by the MAG House of Delegates (1968), and to meet the needs of general operating expenses of the Association for the remainder of the fiscal year 1969 and the fiscal year 1970;

NOW THEREFORE BE IT RESOLVED, that the House of Delegates of the Medical Association of Georgia approves an assessment on the dues-paying members in the amount of \$50 for each of the fiscal years designated.

REFERENCE COMMITTEE RECOMMENDATION—
Mr. Speaker, your Reference Committee considered the report of the Committee on Special Finance of Council and Supplemental Report 69-2 as a single item and recommends approval of these reports with commendation, and with the following additional recommendation: That the recommendations for dues

increases and assessments contained in these reports *not* be recommended, but instead that this House of Delegates adopt the following resolution:

"BE IT FURTHER RESOLVED, that Chapter VIII, Section 3 of the By-Laws of the Association be amended by adding a new subsection (3) to section (A) thereof to read as follows:

"(3) Before June 15, 1969, the Secretary of the Association shall bill each member certified as a member for 1969 in accordance with subsection (1) hereof for additional 1969 dues of \$75 and before June 15, 1969, the secretary of each component county society subject to subsection (2) hereof shall bill each member of his society for additional 1969 dues of \$75 and remit such dues to the Secretary of the Association. Any member whose additional dues for 1969 have not been paid to the Association by September 15, 1969, shall stand suspended until payment of such additional dues."

Mr. Speaker, your reference committee feels that it is necessary to take immediate action on the matter of adequately meeting the financial obligations of this Association. We feel that \$75 per member will be sufficient at this time. We make this recommendation based on testimony received in our hearings.

HOUSE OF DELEGATES ACTION—Speaker Rogers recognized many members of the House of Delegates to speak in support of and opposition to the reference committee recommendation. Speaker Rogers then recognized Charles Cowart, who moved that the amount of "\$75" mentioned in the reference committee recommendation be changed to "\$100." After further discussion, this amendment passed by a vote of 67 for and 33 against. The House of Delegates then adopted the reference committee recommendation as amended.

Dr. Davis then reported that this concluded the report of Reference Committee No. 2 and moved for the adoption of his report as a whole with appreciation to the members of his committee. This motion was duly seconded and approved.

Report of Reference Committee No. 3

Charles Watkins, M.D., Chairman

(The following reports as presented to this reference committee are printed in full with the reference committee's recommendations and the action pursuant to them taken by the House of Delegates.)

Chairman Watkins reported to the House that reports and resolutions referred to Reference Committee No. 3 were considered by the committee which met at 9:00 a.m. in the Augusta National Room of the Savannah Inn and Country Club, Savannah, on May 6, 1969. Members of the committee present included Charles B. Watkins, Chamblee, Chairman; Stuart Prather, Augusta, Vice Chairman; J. Harold Harrison, Atlanta; Robert S. Robinson, Metter; Ollie O. McGahee, Jesup; and Joseph A. Mulherin, Savannah.

Second Vice-President

RONALD F. GALLOWAY, M.D., Augusta

The distinction of having been elected to serve this Association on the Executive Committee of Council is indeed an honor. Working with the members of the Executive Committee is at the same time an education and an important responsibility.

My report to our Association will dwell briefly on two subjects, the first a commendation, and the second a recommendation.

The work of both the Executive Committee and Council itself covers all phases of medicine and the problems of physicians who practice it. With this broad a subject, thorough and up-to-date information must be constantly made available to the Executive Committee of Council. A myriad of details must be worked out to keep the Executive Committee and the Council functioning smoothly. Our Association staff, in its entirety, is to be highly commended for its excellence in seeing to these matters. Not only is the work done efficiently, but in a most pleasant fashion. Our MAG staff deserves thanks not only from the House of Delegates but from all members of the Association.

RECOMMENDATION

The Executive Committee of Council is responsible for many important and sometimes urgent decisions which directly or indirectly concern all members of the Medical Association of Georgia. The decisions of the Executive Committee are, of course, subject to review and approval by the Council. In that members of the Executive Committee are elected to that body by the membership of the Medical Association of Georgia at large, it would seem well worthwhile to amend the by-laws of our organization to allow the second vice president not only a voice in the deliberations of the Executive Committee but a vote as well. This would allow better representation on the Executive Committee by a duly elected officer of the Association. I strongly recommend that action be taken to institute this change.

REFERENCE COMMITTEE RECOMMENDATION—The report of the second vice-president was accepted by the committee. However, the committee, after hearing expressions of concern from several witnesses regarding the number of voting members of the Executive Committee, recommends that the second vice-president not be made a voting member of the Executive Committee as was recommended in this report.

HOUSE OF DELEGATES ACTION—Adopted the reference committee recommendation as presented.

Alternate AMA Delegate

F. W. DOWDA, M.D., Atlanta

This has been another busy year at AMA. Your alternate delegate has been impressed with the increased awareness and activity of our medical students and younger doctors in the field of social action and economics, as well as in the field of medical school curricula.

RECOMMENDATION

It would seem to me incumbent upon us to recognize this and utilize this energy, and I would, therefore, suggest that we make the presidents of the organized chapters of SAMA in the State of Georgia ex-officio members of the MAG Council.

Also, both AMA and MAG have adopted policies supporting the right of direct billing by physicians. As yet this has not been implemented in Medicaid payments.

RECOMMENDATION

I would suggest that we again formally request the Board of Health to institute this policy.

The AMA and MAG have both adopted a new policy on osteopathy. It would seem to me that we can insure quality control and protection of the public only by total amalgamation, the first step of which is the inspection of all schools of medicine and osteopathy by a joint 50-50 Board of Examiners—half from AMA and half from AOA.

REFERENCE COMMITTEE RECOMMENDATION—

This report contained three recommendations. First it recommended the the presidents of the two Georgia SAMA chapters be made ex-officio members of the MAG Council. The committee took note of the fact that the composition of the MAG Council, including the ex-officio members, is defined in Article VI, Section 1 of the constitution. In order to enlarge upon the composition, therefore, a constitutional amendment would be required. Further your reference committee questioned its authority to submit a constitutional amendment not first submitted to Council. Accordingly, the committee recommends that the Constitution and Bylaws Committee investigate this matter and with the approval of Council prepare an amendment to be submitted at the 1970 House of Delegates and that in the interim the presidents of the Georgia SAMA chapters continue to be invited to attend Council meetings as guests.

The second recommendation concerned direct billing under the Title XIX (Medicaid) program which is also the subject matter of Resolution No. 8 and will be considered later in the report under that heading.

The third recommendation concerned amalgamation of medicine and osteopathy and inspection of all medical and osteopathic schools by a joint committee composed of an equal number of examiners from AMA and the AOA. Because this subject matter is so closely related to the subject contained in Resolution No. 9, the committee recommends that this recommendation be disapproved and viewed in light of the action taken on Resolution No. 9.

HOUSE OF DELEGATES ACTION—Adopted the reference committee recommendation as presented.

Chairman of Council

F. G. ELDRIDGE, M.D., *Valdosta*

As Chairman of Council for 1968-69 I wish to submit the following report as a review of the actions of the Council of the Medical Association of Georgia, other than those actions referred to, and reported by,

the various committees charged with the investigation, recommendations, and report of such committees.

Emory University—Grady Hospital Agreement regarding third party payment for services rendered under third party payment programs: It was the opinion of Council, after due consultation with legal counsel, that the agreement between the Emory University Authorities and the Grady Hospital Authority constituted the corporate practice of medicine. The following is a resolution drafted by Legal Counsel and approved by the members of the Council:

RESOLUTION

WHEREAS, the frequently repeated position of the Medical Association of Georgia (hereinafter referred to as "MAG") has been and remains that the corporate practice of medicine, whether for profit or not for profit, is illegal, unethical, and not in the best interest of patients, the public, and physicians;

WHEREAS, Grady Hospital (hereinafter referred to as "Grady") has in the past served indigent patients who paid no professional fees and Grady Hospital was mainly supported by the levy of local taxes but State and Federal funds are now available for the payment of fees for professional services afforded to some indigent patients;

WHEREAS, MAG, Grady and Emory University School of Medicine (hereinafter referred to as "Emory") all wish to see such funds used for the betterment of patient care at Grady;

WHEREAS, professional services to patients at Grady are, in large part, provided or supervised by members of the active staff of Emory who are, according to Emory's rules, full-time faculty members;

WHEREAS, the following events have occurred as understood by the Council of MAG:

(1) Emory, Grady and the Emory active staff entered into a contract whereby all active staff members agreed to collect professional fees payable from such funds to be paid to a medical trust fund with Grady as trustee;

(2) Meetings have been held for discussion of such contract by representatives of Grady, Emory, and MAG, and negotiations have taken place among their legal counsel;

(3) Legal counsel to MAG by a letter of March 8, 1968, to legal counsel to Grady, attached to this resolution as Exhibit A, proposed modifications of the contract to make it satisfy MAG's principles stated in the first WHEREAS clause of this resolution;

(4) Grady and Emory have subsequently modified the said contract to incorporate the suggestions of Exhibit A contained in Subparagraph 3(b) and Paragraph 6 thereof;

(5) Grady's Medical Director discussed said agreement in depth with Council of MAG on June 1, 1968, and asked that any further recommendations of MAG be formally communicated by this Council to Grady and Emory.

NOW, THEREFORE, BE IT RESOLVED AS FOLLOWS:

(1) This Council reaffirms the position of MAG that the corporate practice of medicine, whether for profit or not for profit, is illegal, unethical, and not in the best interest of patients, the public, and physicians;

(2) Grady and Emory are requested to modify said agreement as so amended as follows:

(a) Allow a partnership to be formed as stated in Paragraph 1 of Exhibit A;

(b) Implement the suggestions contained in Sub-paragraphs 3(a) and 3(c) as to terminating said agreement in certain events.

(c) Implement the suggestions contained in Paragraphs 4, 5 and 8 of Exhibit A as to elected representatives of the staff.

(3) Grady and Emory are requested to answer the suggestions contained in this resolution and to give their reasons for positions then taken.

Flex Examination: Council approved the drafting of legislation in accordance with a resolution submitted to Council by the State Board of Medical Examiners providing for a change in statute to substitute the Flex Examination for the present laws regarding examination of Doctors of Medicine. This resolution is printed below.

RESOLUTION

WHEREAS, the Georgia State Board of Medical Examiners is charged by law with formulating such examination as may seem proper to determine the proficiency of those persons seeking to be licensed to practice medicine in the State of Georgia; and

WHEREAS, the current professional mobility of physicians has created the need for the establishment of a standard examination among the several States; and

WHEREAS, the Federation of State Medical Boards of the United States, Inc., has formulated such uniform examination, known as the Federal Licensing Examination, commonly designated FLEX exam; and

WHEREAS, the Georgia State Board of Medical Examiners has reviewed said FLEX examination and believe it to provide a comprehensive and adequate test of medical proficiency; and

WHEREAS, the Emory University School of Medicine and the Medical College of Georgia have endorsed utilization of the mentioned examination; and

WHEREAS, the Medical Association of Georgia Council has endorsed utilization of the mentioned examination; and

WHEREAS, it is desired that the Georgia State Board of Medical Examiners retain the right to set such norms of accomplishment on the examination and to establish such other standards as may be necessary to insure that those persons seeking unrestricted licenses as physicians in the State of Georgia possess a high level of professional competency; and

WHEREAS, the Georgia State Board of Medical Examiners desires to encourage reciprocity of license recognition among the several States.

NOW THEREFORE, BE IT RESOLVED as follows:

(1) That the undersigned Board requests the Attorney General of the State of Georgia to draft legislation providing that, at the election of the Board, the FLEX examination or such other exam as the Board might devise, may be administered to all persons seeking to be licensed as physicians in the State of Georgia after January 1, 1973; provided, however, any group of persons being examined at a given test period shall receive the same examination.

(2) That such legislation provide that the undersigned Board shall have the sole and absolute right to establish such norms of accomplishment on the examination as may, from time to time, seem appropriate.

(3) That the undersigned Board shall continue to have the right to establish such other regulations for licensing as are presently authorized by statute.

(4) That the undersigned Board be authorized to accept the FLEX examination results as administered by any State with which Georgia shares reciprocity, providing the norms of accomplishment required by such State equals or exceeds the standards of the State of Georgia; providing further, that this policy shall not alter other existing rules or regulations touching extensions of reciprocity (except as to examination requirements).

(5) That the Board be empowered to establish such fees for the administration of the exam as may, from time to time, be commensurate with the expense of the Board in procuring such exams.

(6) That a copy of this resolution be forwarded to the Medical Association of Georgia, Emory University School of Medicine and the Medical College of Georgia with the request that said bodies endorse and approve the within and foregoing provisions.

(7) That a copy of this resolution be forwarded to the Honorable Arthur K. Bolton, Attorney General, of the State of Georgia.

THIS RESOLUTION, duly considered and adopted at session of the Georgia State Board of Medical Examiners convened the 10th day of October, 1968, at Atlanta, Georgia.

GEORGIA STATE BOARD OF
MEDICAL EXAMINERS

Y. F. CARTER

C. L. CLIFTON

Council reaffirmed the position of the Executive Committee supporting legislation by the Georgia State Board of Medical Examiners for the establishment of a Composite Board of Medical Examiners to license both Doctors of Medicine and osteopathic physicians.

Council's continued support of the Building Committee is calculated to produce an efficient, functional and impressive Headquarters in which each member can take pride.

Elections: Council received a report from J. W. Chambers, M.D., Chairman of the Ad Hoc Committee on Elections, which reiterated the committee's recommendations of 1967. Council voted to approve their recommendations and refer them to the House of Delegates. That Committee's report as submitted is as follows:

Therefore, your committee would like to make the following recommendations:

(1) That councilors and vice-councilors be elected, not nominated, by their own constituent societies with provision in the Constitution and Bylaws of the Medical Association of Georgia to provide for councilor and vice-councilor election in the event a constituent society defaults in its responsibility. We believe this gives local representation and control:

(2) That the House of Delegates, including the ex-officio members, elect the officers of this Associ-

ation, the AMA delegates and the AMA alternate delegates, as could be provided by proper change in the Constitution and Bylaws; and that nominations be made at the first meeting of the House of Delegates and the election be an order of business at the last meeting of the House of Delegates at each Annual Session. We believe this would stimulate county societies to function more effectively in the choice of an election of their own delegates to the MAG House of Delegates. It would also provide a stimulus of interest in meetings of the county societies to discuss the possible candidates and if they saw fit, to instruct their own delegates prior to the annual meeting.

(3) In the event Recommendation (2) is not approved, we would recommend that an absentee or mail ballot be provided for as follows: (a) Nomination of the candidates be made in writing with the endorsement of their county medical society to the February or March meeting of the MAG Council; (b) The proposed ballot to be published in the April issue of the *Journal of the Medical Association of Georgia*; voting to be done by mail prior to the first meeting of the House of Delegates at the Annual Session; and such ballots to be counted at the same time as the ballots at the Annual Session are counted. Mail ballots could be obtained by written request from the MAG office or persons designated by the president to issue ballots; (c) In the event there was not a majority or there was a tie, a run-off election would be held by ballot of the House of Delegates in its last session of the annual meeting.

We realize Recommendation (3) is cumbersome and perhaps impractical in some ways but it at least would be more democratic than our present method. We also feel that Recommendation (2) would provide election by the most knowledgeable group in the Medical Association of Georgia.

I am personally proud of the excellent attention to the affairs of MAG which this year's Council has displayed and I wish to thank each member for his loyal devotion. A particular note of commendation should be given to Mrs. Hayward Phillips, president of our Auxiliary, who has faithfully represented the physicians' wives at each Council meeting this year. It has been my pleasure to serve as Chairman of the Council for two years and I wish to express my sincere appreciation for having had this honor.

EXHIBIT A

Trammell Vickery, Esquire
Jones, Bird & Howell
Haas-Howell Building
Atlanta, Georgia 30303

Dear Trammell:

The purpose of this letter is to set down the basis on which I would be willing to go to bat to obtain the support of The Medical Association of Georgia and the Fulton County Medical Society to settle the present questions raised about the Agreement of October 1967, among physicians on the faculty of Emory University School of Medicine serving on the professional staff of Grady Memorial Hospital, Fulton-DeKalb Hospital Authority, and Emory University. I would recommend acceptance of Articles of Partnership incor-

porating all of the provisions applicable of the above referenced Agreement but containing the following additional or revised provisions:

(1) Instead of having an agreement signed individually by the licensed physicians who are members of the professional staff at Grady, we would propose to have the same persons form a partnership through Articles of Partnership or Articles of Association. These could and should contain the necessary provisions negating profit motives so that a ruling from the Internal Revenue Service could be obtained to the effect that all income of the Partnership is nonprofit and, therefore, not includable in the gross income of the members of the Partnership for purposes of income taxation.

(2) It seems appropriate to name the Fulton-DeKalb Authority as the Trustee as is done in the above referenced Agreement.

(3) The members of the Partnership (which would include their successors and other persons similarly appointed to the Staff of Grady Hospital whether or not they signed the Articles of Partnership) should be empowered to meet as frequently as necessary for the business of the Partnership and at least annually for the following purposes (which should be specifically stated):

(a) to elect representatives to the General Fund and the Service Fund as hereinafter mentioned;

(b) to review the operations of the General Fund, the Service Fund, and the overall Medical Fund pursuant to reports furnished by the Medical Fund Trust Committee for the purpose of the annual meetings;

(c) to determine whether the operation of the various funds satisfies the staff at Grady. Should it not satisfy the staff at Grady, the inherent power would be reserved in the Partners to terminate the Partnership and thus the current arrangement for the handling of Medicare fees.

(4) The Medical Staff, Partners of the Partnership, each member having one vote, should be entitled at the annual meeting to elect one person to serve with the Medical Director of Grady Hospital and the Dean of the Emory Medical School in making decisions concerning the use of the General Fund.

(5) At the annual meeting of the medical staff, the members of the Partnership who are members of a particular service would be entitled to vote for and elect one representative to serve with the Chief of that Service and the Medical Fund Trust Committee in arriving at decisions as to the use of the portion of the Service Fund allocable to the particular service. I would suggest that decisions as to the use of a particular Service Fund could only be made if the Medical Fund Trust Committee agrees with the recommendations and decisions of the Service representative and the Chief of the Service. In other words, there is no intent on my part to suggest that final decisions should be vested anywhere other than in the Medical Director of Grady Hospital and the Dean of the Emory University School of Medicine subject to review by the Fulton-DeKalb Hospital Authority.

(6) There should be a provision allowing any member to make written recommendations to the Medical

Fund Trust Committee as to the use of the General Fund and as to the use of the particular Service Fund. Provision should be made requiring the particular committee to consider all written recommendations and answer in writing as to the disposition of such recommendations.

(7) I believe one simplification could be made. The name of the Partnership could be the same as the Trust. Billings could be made in the name for the Partnership and deposited directly to the Trust Account with disbursements governed as stated in the October Agreement. This would eliminate the need for endorsements of checks unless Medicare insists on making checks payable to the particular physician rendering the services. I do not believe Medicare will require the check to be made to the individual rendering the service so long as the individual rendering the service signs the claim form and directs payment of the check to the Partnership of which he is a member.

(8) I think it would be wise to provide that in the event of an impasse between the members of the Medical Fund Trust Committee (see Article VII(H), p. 22 of October Agreement), the impasse would be resolved by adding to the Medical Fund Trust Committee the two Chiefs of Services at Grady Hospital who are senior in point of service as Chiefs of Service and the representative to the General Fund elected by the entire membership of the Partnership at the annual meeting of the Staff.

I shall appreciate your careful review of this letter and your advice to me as to any changes necessary to make it possible for you to recommend strongly to your clients.

I would hope that you and I could be in agreement as to what we would recommend in time for me to present the matter to the Council of The Medical Association of Georgia at its meeting on March 15.

With kind regards.

Sincerely,
JOHN L. MOORE, JR.

REFERENCE COMMITTEE RECOMMENDATION—

Your committee recommends that the House of Delegates affirm the position taken by the MAG Council regarding the contract signed by Emory University and Grady Hospital on the matter of third party payment for services rendered under third party payment programs. It further recommends that the Council pursue this matter with a view toward obtaining alterations in the contract to eliminate those aspects of the contract considered to be the illegal corporate practice of medicine by both parties to the contract.

Your committee also took note of the inclusion of Council endorsement of the FLEX Examination bill. The FLEX Examination bill authorizes the State Board of Medical Examiners to administer an examination to candidates for medical licensure devised by the Federation of State Licensing Boards. This bill was enacted into law.

Consideration of references to the composite board of medical and osteopathic examiners was considered together with Resolution No. 9.

Report of the Chairman of Council also included a recommendation that the officers of the Association be elected by the House of Delegates. Following thorough and exhaustive consideration of this matter the committee voted to refer this matter back to the

House of Delegates without recommendation. Considerable concern was expressed by various witnesses regarding the use of a "mail ballot." However, in view of the fact that this was submitted as a "cumbersome and perhaps impractical . . ." alternative to election by the House of Delegates, your committee took no action and refers this also to the House of Delegates without recommendation.

HOUSE OF DELEGATES ACTION—Speaker Rogers recognized Delegate J. Frank Walker of Fulton County, who moved that recommendation No. 2 of the Ad Hoc Committee on Elections be adopted with the deletion in the first sentence of the words "including the ex-officio members" so that recommendation No. 2 would read, "that the House of Delegates elect the officers of this Association, the AMA delegates and the AMA alternate delegates, as could be provided by proper change in the Constitution and Bylaws; and that nominations be made at the first meeting of the House of Delegates, and the election be an order of business at the last meeting of the House of Delegates at each Annual Session." Dr. Walker also moved that the necessary changes be made in the Constitution and Bylaws to accomplish the intent of this recommendation. The motion was seconded and carried by a vote of 80 for, 16 against.

The House then adopted the reference committee recommendation as amended.

Fulton County Medical Society Councilor

J. HAROLD HARRISON, M.D., *Atlanta*

During my tenure on the Council it has become apparent that increasing involvement of the third party, including the government, health insurance agencies and others, in policies concerning the present and future delivery of medical services is ominous.

Organized medicine, if it is to maintain its proper perspective in pursuing a significant role in the shaping of its destiny, must adjust to the time. One basic move is adopting rules prohibiting the development of conflicts of interest in its political leaders.

RECOMMENDATIONS

It is, therefore recommended that individuals holding policy-making offices in the Medical Association of Georgia should not be simultaneously employed by the government, health insurance companies or other third party agencies in positions pertaining to activities in these matters.

REFERENCE COMMITTEE RECOMMENDATION—

The purpose of this report as explained by the author was to eliminate conflicts of interest that might arise by reason of elected officers of MAG simultaneously holding positions with government, health insurance companies or other third party agencies. The committee was concerned that the recommendation as written was subject to more than one interpretation and accordingly recommends adoption of the following rewritten version of that recommendation:

It is, therefore recommended that individuals holding the policy-making offices as defined in the MAG Constitution and Bylaws in the Medical Association of Georgia should not be simultaneously



Fletcher N. Platt, manager of Ford Motor Company's Traffic Safety and Highway Improvement Department, participated in a panel on automotive safety.

employed by the government, health insurance companies or other third party agencies in positions pertaining to activities in these matters which create a conflict of interest; and, that the presence or absence of conflict of interest be presented to the Executive Committee of Council for study and that recommendations for action be submitted to Council for final action.

HOUSE OF DELEGATES ACTION—Adopted the reference committee recommendation as presented.

Constitution and Bylaws

GEORGE H. ALEXANDER, M.D., *Chairman*

A meeting of the committee was called for at 2:00 p.m. on November 1, 1968, to be held at the Headquarters Office. Copies of the minutes of this meeting in full may be obtained from the Chairman or the Headquarters staff. A brief summary follows:

The Chairman was the only member of the committee present as the other members were unavoidably prevented from coming. Mr. John Moore, MAG legal counsel was also present, as was Mr. James M. Moffett from the Headquarters Office.

In the absence of a quorum, your Chairman directed that attention to the Constitution and Bylaws be divided into two categories. First, the editorial and typographical changes which would require no action of Council and the House of Delegates to make, and second, changes of substance, requiring amendments to be acted on by the House of Delegates, after first being submitted to Council. Accordingly, these changes are being made by Mr. Moffett and the Chairman

with the concurrence of legal counsel. Legal counsel was requested to draft certain other amendments to be submitted to the committee members for approval prior to submission to Council at the December 1968 meeting for approval in principle.

The proposed amendments will be submitted at the end of the report, along with necessary explanatory comments.

A second meeting of the committee was called for 1:00 p.m., Sunday, January 12 at Headquarters Office. Those present at this meeting were: George H. Alexander, Chairman; Linton H. Bishop and Virgil Williams. Also present were: Mr. William B. Spann, legal counsel and Mr. James M. Moffett as staff.

The minutes of the previous meeting were reviewed, together with changes suggested by Council and the later drafts prepared by legal counsel.

Pursuant to the above reported meetings, the committee submits the following together with its recommendations to the House of Delegates. It is recognized that the committee's recommendations go to the House through Council. Council may or may not concur in the committee recommendations and the same is true as to the concurrence of the House as referable to both the committee's recommendations and recommendations of Council.

Editorial note: Council voted at its March meeting to make no recommendations, either for or against, regarding these proposals.

PROPOSED AMENDMENTS OF THE CONSTITUTION AND BYLAWS OF THE MEDICAL ASSOCIATION OF GEORGIA

Be it resolved that the Constitution and Bylaws of the Medical Association of Georgia be amended in the following particulars:

Present Constitution:

ARTICLE VII, SECTION 3. SPECIAL MEETINGS. Special meetings of either the Association or the House of Delegates may be called by a two-thirds vote of Council, 20 delegates or upon written petition of one-fourth of the members of the Association.

Proposed Constitutional Amendment:

Amend Article VII, Section 3 of the Constitution by striking Section 3 in its entirety and inserting in lieu thereof a new Section 3:

"SECTION 3. SPECIAL MEETINGS. Special meetings of either the Association or the House of Delegates may be called by a two-thirds vote of Council, upon written petition of one-third of the delegates of the House of Delegates, or upon written petition of one-fourth of the members of the Association."

COMMENT: The present Constitution provides that special meetings may be called by two-thirds vote of Council or twenty delegates or upon written petition of one-fourth of the members of the Association. Since there are 26 voting members of Council, it can be seen that it would require 18 members to call a special meeting of the Association; whereas, 20 members of the much larger House of Delegates could call a special meeting.

COMMITTEE RECOMMENDATION: To be laid on table for action one year hence.

Present Bylaws:

CHAPTER I, SECTION 3. Membership in the Association shall be classified as Active, Service, Associate, Affiliate, and Honorary. All eligible members should be encouraged to be active members.

Proposed Bylaws Amendment:

Amend Chapter I, Section 3 of the Bylaws by striking said Section in its entirety and inserting in lieu thereof a new Section 3:

"SECTION 3. CLASSES OF MEMBERSHIP. Membership in the Association shall be classified as Active, Service, Associate, Affiliate, Honorary, Life and Student. All eligible members should be encouraged to be active members.

Present Bylaws:

CHAPTER I, SECTION 4. ACTIVE MEMBERS. Physicians who are members in a component county medical society and are eligible to vote and hold office in the society shall be Active Members, unless otherwise classified by action of the component county society. These members shall have full privileges of Association membership including the right to hold office and vote, the privilege of Medical Defense and receipt of the *Journal of the Medical Association of Georgia*, and these members shall pay full dues to the Association annually. New members entering practice after July 1 may pay one-half the annual dues.

Active members may be excused from the payment of Association dues for one of the following reasons: (1) financial hardship or illness, (2) postgraduate training, defined as that period during which a member participates in an organized training course within a hospital, (3) being retired from active practice, or (4) on temporary service, as full-time commissioned Medical Officers in the Reserve Armed Forces. A member excused from the payment of annual dues for service in the Armed Forces shall not be required to pay annual dues for the period beginning January 1 or July 1 following the date of the member's entrance into service. (5) A member in good standing who is over 70 years of age may also be excused from the payment of Association dues upon his application to the Association through his component county society; this exemption to begin the year following the member's 70th birthday. Active members excused from the payment of Association dues shall have the right to vote and hold office but shall not have the privilege of Medical Defense and shall not receive any publication of the Association except by personal subscription. Nothing in this section shall be construed to be retroactive to affect previously elected Life Members.

Proposed Bylaws Amendment:

Amend Chapter I, Section 4 of the Bylaws by striking the second paragraph of said Section 4 in its entirety and inserting in lieu thereof a new second paragraph:

"Active members may be excused from the payment of Association dues for the duration of one of the following circumstances: (1) Financial hardship or illness, (2) postgraduate training, defined as that period during which a member participates in an organized training course within a hospital, (3) being retired from Active practice, or (4) service in the Armed

Forces during a national emergency or compulsory service under the Selective Service System or temporary service as a full-time commissioned Medical Officer in the Reserve Armed Forces. Relief from payment of dues shall not become effective until a lapse of 90 days, at which time it will become retroactive and extend through the applicable period. Dues exemption of active members when granted shall be upon recommendation of the member's constituent local society."

Present Bylaws:

CHAPTER I, SECTION 5. SERVICE MEMBERS. Physicians eligible for Service Membership are all full-time commissioned Medical Officers of the Government, in the U. S. Army, Navy, Air Force, United States Public Health Service, Veterans Administration, and Indian Service, and those physicians who have retired from the Services by federal law. Service members need not be licensed to practice medicine in the State of Georgia provided they are physicians holding the degree of Doctor of Medicine or Bachelor of Medicine from a medical college acceptable to the Council of the Association. Such members shall not be required to pay the annual dues and shall not be entitled to vote and hold office and shall not have the privilege of Medical Defense, nor shall they receive any publication of the Association except by personal subscription.

Proposed Bylaws Amendment:

Amend Chapter I, Section 5 of the Bylaws by striking the last sentence and inserting in lieu thereof a new sentence:

"Such members shall not be required to pay the annual dues and they shall not be entitled to vote or hold office; nor shall they receive any publications of the Association except by personal subscription."

Present Bylaws:

CHAPTER I, SECTION 6. ASSOCIATE MEMBERS. Associate membership may be granted to physicians who are engaged in state and county medical services and full-time salaried members of approved medical faculties provided similar action has been taken by the component county society. Associate membership, except as otherwise provided herein, also may be granted to any member of a component county medical society. Associate members shall pay no dues and shall not be entitled to vote or hold office. They shall not be entitled to the privilege of Medical Defense or to receive any publication of the Association except by personal subscription.

Proposed Bylaws Amendment:

Amend Chapter I, Section 6 of the Bylaws by striking the fourth sentence thereof and inserting in lieu thereof a new fourth sentence:

"They shall not be entitled to receive any publication of the Association except by personal subscription."

Present Bylaws:

CHAPTER I, SECTION 7. AFFILIATE MEMBERS. Persons in the following classes may become affiliate members:

a. American Physicians, located in foreign countries or possessions of the United States, and engaged in Medical Missionary and similar educational and philanthropic labors;

b. Dentists, who hold the degree of D.D.S., or D.M.D., who are members of their state and local dental societies;

c. Pharmacists who are active members of the Georgia Pharmaceutical Association;

d. Veterinarians who hold the degree of D.V.M. and are members of the Georgia Veterinary Association;

e. Teachers of Medicine, or of the sciences allied to medicine, and are not eligible to membership;

f. Scientists in sciences allied to Medicine and who are not eligible to membership.

All nominations must be made by component county medical societies and approved by the Council of MAG not later than the meeting prior to the Annual Session. A majority vote of the House of Delegates shall elect to affiliate membership.

Affiliate members shall not be required to pay membership dues, and shall enjoy the privileges of the scientific meetings without the right to vote and hold office, and shall not be entitled to receive any publication, except by subscription.

Proposed Bylaws Amendment:

Amend Chapter I, Section 7 of the Bylaws by striking subsections e and f in their entirety and insert in lieu thereof new subsections e and f:

"e. Teachers of Medicine, or of the sciences allied to medicine who are not eligible for membership;

"f. Scientists in sciences allied to Medicine and who are not eligible for membership."

Present Bylaws:

CHAPTER I, SECTION 7. AFFILIATE MEMBERS. Persons in the following classes may become affiliate members:

a. American Physicians, located in foreign countries or possessions of the United States, and engaged in Medical Missionary and similar educational and philanthropic labors;

b. Dentists, who hold the degree of D.D.S., or D.M.D., who are members of their state and local dental societies;

c. Pharmacists who are active members of the Georgia Pharmaceutical Association;

d. Veterinarians who hold the degree of D.V.M., and are members of the Georgia Veterinary Association;

e. Teachers of Medicine, or of the sciences allied to medicine, and are not eligible to membership;

f. Scientists in sciences allied to Medicine and who are not eligible to membership.

All nominations must be made by component county medical societies and approved by the Council of MAG not later than the meeting prior to the Annual Session. A majority vote of the House of Delegates shall elect to affiliate membership.

Affiliate members shall not be required to pay membership dues, and shall enjoy the privileges of the scientific meetings without the right to vote and hold office, and shall not be entitled to receive any publication, except by subscription.

Proposed Bylaws Amendment:

Amend Chapter I, Section 7 of the Bylaws by striking the "and" appearing as the seventh word of the third line of the last paragraph and inserting in lieu thereof the word "or."

Present Bylaws:

CHAPTER I, SECTION 8. HONORARY MEMBERS. Physicians and persons holding the degree of Doctor of Philosophy who have risen to prominence in their professions may be elected to Honorary Membership by the House of Delegates. Nominations for Honorary Membership may be submitted to the House of Delegates by component county societies or Council. These members shall enjoy all the privileges of the Association but shall not vote or hold office nor shall they receive the privilege of Medical Defense or any publication of the Association except by personal subscription.

Proposed Bylaws Amendment:

Amend Chapter I, Section 8 of the Bylaws by deleting the following words pertaining to Medical Defense appearing in the last sentence of said section: "the privileges of Medical Defense or." The last sentence then would read as follows:

"These members shall enjoy the privileges of the Association, but shall not vote or hold office, nor shall they receive any publication of the Association except by personal subscription."

Present Bylaws:

CHAPTER I, SECTION 9: (This amendment contemplates the addition of a new Section 9 and does not repeal the old Section 9 of Chapter I. Old Section 9 would be renumbered and dealt with in a later amendment.)

Proposed Bylaws Amendment:

Amend Chapter I of the Bylaws to add a new Section 9:

SECTION 9. LIFE MEMBERS. A member in good standing who is 70 years of age may be classified as a Life Member and excused from the payment of Association dues and assessments upon his application to the Association through his component county society as follows: His application shall be granted in due course if such member has been continuously an active dues paying member of this Association for 25 years. His application shall be granted in due course if he has been an active dues paying member of this Association and any other constituent association or associations of the American Medical Association continuously for 25 years provided he has been an active dues paying member of this Association for at least 10 years of those 25 years. His application may be granted upon action of Council if he has been an active dues paying member of this Association and any other constituent association or associations of the American Medical Association continuously for 25 years but has been an active dues paying member of this Association for less than 10 years. Service in the Armed Forces during a national emergency or compulsory service under the Selective Service System or temporary service as a full-time commissioned Medical Officer in the Reserve Armed Forces shall count as part of the period of continuous years of dues paying membership. Life Members excused from the payment of Association dues shall have the right to vote and hold office but shall not receive any publications of the Association except by personal subscription.

The Committee on Constitution and Bylaws recommends that if the new Section 9 is adopted that

Council provide a suitable certificate to be awarded at Annual Sessions for those members being awarded Life Membership.

Present Bylaws:

CHAPTER I, SECTION 10: (This amendment contemplates the addition of a new Section 10 and does not repeal old Section 10 of Chapter 1. Old Section 10 would be renumbered and dealt with in a later amendment.)

Proposed Bylaws Amendment:

Amend Chapter I of the Bylaws to add a new Section 10:

“SECTION 10: STUDENT MEMBERS. Any person certified by the Secretary of a component county medical society to be a student member thereof may, upon such certification by such Secretary, become a student member of this Association upon proof that such person is a student in good standing at a medical school approved by the State Board of Medical Examiners or an intern or resident in a hospital the internship program of which is approved by the State Board of Medical Examiners. Student members shall not be required to pay membership dues and shall enjoy the privileges of membership of the Association without the right to vote or hold office and shall not be entitled to receive any publication of the Association except by subscription.”

Present Bylaws:

CHAPTER I, SECTION 9. TENURE. When the Secretary is officially informed that a member is not in good standing in his component society, he shall remove the name of that member from the membership roll.

CHAPTER I, SECTION 10. TRANSFER. Should a member remove his practice to another jurisdiction he shall apply for a continuance of his membership through the component society in the jurisdiction to which he has moved his practice.

CHAPTER I, SECTION 11. JURISDICTION. It shall be the policy of this Association and its component county medical societies that its members shall belong to the component county medical society having jurisdiction of the county of their predominant practice. When no such component county medical society has jurisdiction of the county in which a member has his dominant practice, such member shall belong to a component county medical society having jurisdiction of a county adjacent to the county in which the member has his dominant practice. This shall not necessarily be retroactive.

CHAPTER I, SECTION 12. The words “full-time” wherever used in this Chapter shall mean no time at all is devoted to private practice.

Proposed Bylaws Amendment:

Amend Chapter I of the Bylaws by renumbering old Sections 9, 10, 11, and 12 to read Sections 11, 12, 13 and 14.

Present Bylaws:

CHAPTER IV, SECTION 9. COMMITTEE ON FINANCE. The Chairman of the Council shall appoint from among its members a committee of three members to be known as the Committee on Finance, which shall cause to be audited all accounts of the Association. The Council shall propose an annual budget for the

fiscal year beginning January 1st after each Annual Session. Each Committee shall submit to the Committee on Finance its budget for the following year at such time as the Committee on Finance may designate. This proposed budget shall be prepared by the Committee on Finance for the consideration of the Council at the last meeting in the last quarter of each year. This budget shall be presented to the House of Delegates for its approval. It shall also submit an annual report to the House of Delegates, which shall specify the character of all of its property and shall provide full information concerning the management of all affairs of the Association which the Council is charged to administer.

All expenditures made by the Local Arrangements Committee in connection with the Annual Session must be authorized in advance by the Committee on Finance. Council shall have control of all commercial exhibits at the Annual Sessions and any deficit created on account of the Annual Session shall be met by Council on recommendation of the Committee on Finance.

Proposed Bylaws Amendment:

CHAPTER IV, SECTION 9, COMMITTEE ON FINANCE. The Chairman of the Council shall appoint from among its members a committee of three members to be known as the Committee on Finance, which shall cause to be audited all accounts of the Association. The Committee shall propose an annual budget for the fiscal year beginning June 1, and running through May 31. Such budget shall be subject to modification and approval of the Council. Each Committee shall submit to the Committee on Finance its budget for the following fiscal year at such time as the Committee on Finance may designate. This proposed budget shall be prepared by the Committee on Finance for the consideration of the Council at the last meeting in the last quarter of each fiscal year. This budget shall be presented to the House of Delegates for its approval. It shall also submit an annual report to the House of Delegates which shall specify the character of all of its property and shall provide full information concerning the management of all affairs of the Association which the Council is charged to administer.



John R. Montgomery, M.D. and Robert D. Leachman, M.D. of Houston, Tex. and the Rev. Mr. Paul B. McCleave of Chicago, Ill. participate in the Cardiac Transplant Symposium.

All expenditures made by the Local Arrangements Committee in connection with the Annual Session must be authorized in advance by the Committee on finance. Council shall have control of all commercial exhibits at the Annual Sessions and any deficit created on account of the Annual Session shall be met by Council on recommendation of the Committee on Finance.

Present Bylaws:

CHAPTER VII, SECTION 10. DISTRICT SOCIETIES. District societies shall have one or more meetings during the year and shall nominate a Councilor and Vice-Councilor as provided in these Bylaws. These district societies shall be organized for the best interests of the medical profession in Georgia and shall not necessarily conform with the boundaries of congressional districts. District societies shall elect officers, adopt a constitution and bylaws in conformity with the Constitution and Bylaws of the Medical Association of Georgia and levy dues for the government of its own affairs.

Proposed Bylaws Amendment:

Amend Chapter VII, Section 10 of the Bylaws by striking the first sentence thereof in its entirety and inserting in lieu thereof a new sentence:

"District societies shall have one or more meetings during the year and shall elect a Councilor and Vice Councilor as provided in these Bylaws."

Present Bylaws:

CHAPTER VIII, SECTION 3. (C) For the purpose of medical defense a member shall be deemed in arrears from and during the period extending April 1st of the current year until his dues and assessments shall have been received at the office of the Association, having been remitted by the Secretary of the component county society of which he is a member.

CHAPTER VIII, SECTION 3. (D) Any county society which fails to make the reports required before the Annual Session of the Association shall be held suspended, and none of its members or delegates shall be permitted to participate in any of the proceedings of the Association or of the House of Delegates.

Proposed Bylaws Amendment:

Amend Chapter VIII, Section 3 of the Bylaws by striking subsection (C) in its entirety and by redesignating subsection (D) of Section 3 as subsection (C).

It should be noted that the amendments concerning Life Membership and Student Membership were prepared at the request of the Executive Committee.

The amendment changing the fiscal year (Chapter IV, Section 9) was prepared upon direction of Council at its March 8-9, 1969, meeting.

Attention should be called to the constitutional amendment which has been "on the table" since last year's annual session. This concerns the immediate past president's serving a total of three years following his presidency as a member of Council.

The committee further strongly recommends that the Constitution and Bylaws as amended by the House of Delegates be carefully "proof-read" and approved by the Constitution and Bylaws Committee and/or Executive Committee prior to publication. The last publication has required numerous typographical and editorial corrections.

Much work has been done on this report by Mr. John Moore and Mr. Jim Moffett, and it could not have been prepared without their assistance. This assistance is very greatly appreciated.

REFERENCE COMMITTEE RECOMMENDATION—Your reference committee acknowledges receipt of a proposed amendment to Article VII, Section 3 of the Constitution. This amendment would change the criterion for calling a special meeting of the Association or the House of Delegates.

Presently the Constitution provides that special meetings may be called on written petition of 20 delegates to the House of Delegates. This amendment would increase this to one-third of the membership of the House of Delegates. At its present level of 165 delegates, this would mean that it would require 55 delegates to call a special meeting of the House or the Association.

Because this is a constitutional amendment it cannot be voted on at this session of the House, but must lay on the table for a year to be voted on at the 1970 session.

Another constitutional amendment not included in the written report of the Constitution and Bylaws Committee, but approved by Council in meeting May 3, 1969, was received and will be placed on the table for consideration in 1970. This amendment which provides for the election (not nomination) of councilors and vice-councilors by their respective constituent societies is as follows:

Strike Section 2 of Article IX of the Constitution and Bylaws in its entirety and insert in lieu thereof the following:

ARTICLE IX, Section 2. Election and Eligibility. The Officers of the Association, with the exception of the councilors and vice-councilors, shall be elected during the Annual Session as provided for in the Bylaws. Councilors and vice-councilors shall be elected as provided for in the Bylaws. No member shall serve as an officer who has not been a member of the Association for the preceding three years.

Your reference committee would also call to your attention a constitutional amendment offered at the 1968 session of the House of Delegates that was properly placed on the table and can now be voted on by the House. This was presented as an amendment to Article VI, Section I, as follows:

"ARTICLE VI, Council, Section 1. COMPOSITION. Council is composed of the president, the president-elect, the immediate past-president, the two preceding immediate past-presidents, two vice-presidents, secretary, speaker of the House of Delegates and councilors as provided for in the Bylaws. Delegates to the AMA, the treasurer, editor of the *Journal* and the executive secretary shall be ex-officio members of Council without the right to vote. Vice-councilors shall be ex-officio members except in the absence of their respective councilors as provided for in the Bylaws. The vice-speaker shall be an ex-officio member except in the absence of the speaker as provided for in the Bylaws."

Your committee recommends approval of this amendment to the Constitution.

Many of the amendments to the Bylaws were technical in nature, designed to correct minor imperfections, typographical errors and petty inconsistencies with the clear intent and meaning of the Bylaws. Your committee recommends approval of these amendments. Several, however, were amendments of consequence and merit explanation, together with the committee's recommendations. They are:

Chapter I, Section 9: LIFE MEMBERSHIP. This proposal contemplates the addition of a new Section 9 to Chapter I of the Bylaws. It provides for Life Membership and the excuse from payment of dues and assessments if a member is 70 years of age and has been a member of MAG for 25 years; or if he has been a member of any constituent association of the AMA for 25 years provided he has been an MAG member for 10 of the total of 25 years required; or if he has been a member of any constituent association of the AMA for 25 years, but has been a member of MAG for fewer than 10 years, provided Council approves his application. Service in the Armed Forces would count as part of the continuous years of dues paying membership required.

Your committee recommends approval of this amendment.

Your committee also approves the recommendation that authorizes Council to provide a suitable certificate to be awarded at Annual Sessions to those members being given Life Membership.

Chapter I, Section 10: STUDENT MEMBERS: This proposal provided for a classification of student membership where a county medical society admits student members. The amendment originally provided that residents and interns could also qualify for this class of membership. However, your committee agreed with witnesses before the committee that residents and interns should be afforded Associate Membership and accordingly recommends that Chapter I, Section 10, as submitted by the Constitution and Bylaws Committee be changed to place a period following the word "Examiners" on Line 27, page 7 of the report and the deletion of the remainder of that sentence down through the word "Examiners" appearing on line 30, page 7 of the report.

Your committee further recommends that Chapter I, Section 6. ASSOCIATE MEMBERS, be amended by inserting between the words "faculties" and "provided" in the fourth line of said section the following language "intern or resident in a hospital the internship program of which is approved by the State Board of Medical Examiners."

HOUSE OF DELEGATES ACTION—Adopted the reference committee recommendation as presented.

National Legislation

J. FRANK WALKER, M.D., *Chairman*

Because of the early deadline required of this report, your chairman will deal in this instance only with matters that relate to national legislation. A Supplemental Report detailing State legislative matters will be filed at a later date.

Even though the 91st Congress is but two months old at the writing of this report, already it has evi-

denced considerable interest in medical legislation, as did its predecessors, the 90th and 89th Congresses.

A matter of interest carried over from last year is the hearings being conducted by the Ways and Means Committee to determine the position of the Federal taxing authorities regarding "unrelated income" earned by tax exempt organizations. MAG interest in this matter centers on the effect taxation of such income would have on the continued publication of the MAG and AMA scientific journals.

Another matter of considerable concern is the large number of bills that have been introduced in the House (one in the Senate S. 746) which would amend Part B of Medicare to provide for payment for services of chiropractors. All of these bills were introduced in spite of the report filed with the Congress in December 1968 by the Department of Health, Education and Welfare, which recommended that chiropractors remain excluded from the program. Your Legislative Committee will oppose these bills vigorously.

As in years past, the committee hosted the members of the Georgia delegation in the Congress at a luncheon held at the Capitol in Washington. The 1968 Congressional Luncheon differed from previous such gatherings in that it was scheduled to coincide with the AMPAC National Workshop. This proved to be a successful combination and it is planned that the 1969 trip will be similarly scheduled.

The Congressional Luncheon, which was begun ten years ago, has continued to be one of the best political relations programs of the Association. A physician from each congressional district is asked to attend and serve as host for his own congressman. The trip includes briefings by the AMA Washington office, visits with the congressmen in their offices for discussion of issues and fellowship embodied in the luncheon. A short program follows the luncheon in which we give each of the congressmen and Senators an opportunity to talk to the physician representatives of the committee as a whole on any subject he elects. Most frequently they choose to speak on pending medical legislation.

REFERENCE COMMITTEE RECOMMENDATION—Your committee approves with commendation the report of the Committee on National Legislation and commends the committee for the service it has performed in the past.

HOUSE OF DELEGATES ACTION—Adopted the reference committee recommendation as presented.

State Legislation

HARRISON L. ROGERS, M.D., *Chairman*

The 1969 session of the Georgia General Assembly was the most difficult and unpredictable one in the memory of anyone presently associated with the legislative program of the Association. Forty-five meeting days stretched over a 73-day span clearly marked the '69 session as one of the longest on record in modern times. The slow transformation of the General Assembly from rural to urban domination (not yet complete) has created power vacuums not yet filled. The relationship of the Governor to the Legislature with its newly asserted independence, a hotly contested struggle over taxes and expenditures, and the

vague emergence of candidates for the 1970 elections added greatly to the difficulties associated with any session of the Georgia General Assembly.

The obvious increased interest in health and related matters seeking legislative clarification clearly signifies that the legislative affairs of the Association will become more complex in the future.

The following list of bills and actions taken on them is an accounting of the more important matters of concern to the medical profession considered by the 1969 General Assembly:

Anatomical Gift Act—The Georgia Anatomical Gift Act will make it possible for a person to execute a legally binding Will that includes among its provisions authority for the giving of one's body (or a part thereof) for medical and dental education and research, banking and storage, and transplantation. The real essence of the bill is that the Will (that portion related to anatomical gifts) would not have to be probated before it becomes effective and thus avoids delay which would tend to make the gift useless. This was an MAG-sponsored bill. *It passed both the House and Senate and was signed into law by the Governor.*

Mental Patients' Bill of Rights—The Bill of Rights for mental patients attempts to revise comprehensively the laws relating to commitment, hospitalization and release of mentally ill persons. It provides for the statutory codification of the rights which must be afforded all persons voluntarily and involuntarily committed, and the legal procedures which must be followed throughout. The bill provides for emergency treatment facilities, evaluation facilities and hospital treatment facilities. It further provides for periodic court review of the necessity for continued treatment and legal representation for the patient (court appointed if necessary) at every step in the process. *MAG supported this bill.* (Although the bill passed the House and Senate at the time of writing this report the Governor has not yet signed it.)

Psychiatric and Psychological Insurance Coverage—Senate Bill 41, a bill relating to insurance coverage for psychiatric treatment, and House Bill 53, a bill related to psychology insurance coverage will be treated together in this report for reasons that will become obvious.

S.B. 41 as introduced would have required insurance companies doing business in Georgia to extend their coverage to include psychiatric treatment. MAG opposed this bill on the basis that it violated the right of contract and would have resulted in a situation whereby no one could purchase a health insurance policy in Georgia that did not include this coverage. This bill was amended by committee to provide that in cases where a policy does not include psychiatric treatment, a statement to this effect in bold type must appear on the policy. In addition, the bill was amended to provide that where a policy does cover psychiatric treatment, that policy holders would be entitled to reimbursement when such treatment is rendered in any psychiatric hospital duly licensed by the State of Georgia. (Some insurance companies now define a hospital as one that includes surgery and have refused to pay for care rendered in a psychiatric hospital that did not include surgery.)

H.B. 53 would have required commercial insurance companies to reimburse for services rendered by ap-

plied psychologists when such services were rendered within the scope of their practice privileges. MAG also opposed this bill on the basis that insurance companies should not be required to cover the services of groups of practitioners except those of his own choosing, and on the basis that the services of non-medical mental health professionals should be covered only when such services are rendered in meaningful collaboration with physicians. This bill never emerged from committee and, in fact, was given a "do not pass" label by a subcommittee of the House Committee on Insurance.

S.B. 41, as amended, passed the Senate. When called up for a vote in the House it was amended to include a substitute version of H.B. 53 and was subsequently passed by the House. The substitute version provided that the services of psychologists must be reimbursed when they were provided on a referral basis from a physician. A conference committee (three members from each chamber) was appointed and the provisions relating to psychologists were "knocked out" of the bill. The House defeated the conference report and the net effect of this is that neither S.B. 41 nor H.B. 53 (or substitute) were enacted. Both remain as live bills, however, and could be passed at the 1970 session.

Professional Tax—Prior to the passage of H.B. 87, the Professional Licensing Tax bill, the maximum professional licensing tax that could be imposed under Georgia law by any municipality or county was \$15. H.B. 87, as introduced, provided for the removal of this ceiling which would have permitted local taxing authorities to impose a license tax on specified professionals (including M.D.'s) at any level they chose. This bill passed the House.

MAG opposed the bill vigorously in the Senate on the basis that a "sky's the limit" approach would amount to an unwarranted raid on the personal income of medical practitioners. This bill was subsequently amended to set a limit of \$200 that may be imposed by local taxing authorities. Enactment of this bill does not, of course, mean that the \$200 ceiling will be used in all cases—but it could be.

Assessment of the enactment of this bill as a loss or a win "of sorts" is difficult to make. An increase in the maximum tax from \$15 to \$200 is, on its face, a loss. Specifying a limit of \$200, in view of how close we came to no ceiling whatever, could be viewed as a win.

Sterilization—Present law in Georgia authorizes deliberate sterilization only in cases of married persons, with the consent of the spouse and the concurring opinions of two medical practitioners.

H.B. 255, as introduced, would have permitted a sterilization procedure to be performed on anyone married or unmarried, of legal age or a minor, of sound mind or incompetent. MAG objected to this bill and it was subsequently amended to permit a legally performed sterilization procedure on anyone of sound mind, 18 years of age and older. Although MAG did not support the bill, as amended, it did withdraw its objections. The bill was reported from Committee but never called up for a vote in the House. It remains a live bill and could be voted on at the next session.

Transfer of Mental Patients—H.B. 263 authorizes the Health Department to receive from other States mental patients for hospitalization in Georgia insti-

tutions. The bill was conceived for the benefit of those Georgia citizens who have relatives in mental institutions of other States who desire to have them returned to Georgia for continued hospitalization. **THIS BILL PASSED THE HOUSE AND SENATE.**

Flex Examination—Passage of the FLEX Examination bill authorized the Board of Medical Examiners to administer examinations appropriate to its function to prospective candidates for medical licensure, and also to administer an examination developed by the Federation of State Examining Boards. This examination is designated as FLEX. Promoted by the Board of Medical Examiners as an examination vastly more comprehensive than any ever given by the Board before, MAG supported this bill through both chambers and it passed in both. (Bill not yet signed by the Governor as of the writing of this report.)

Chiropractic—There were two bills dealing with chiropractic introduced at the '69 session. H.B. 354, introduced with 21 signatures (co-sponsors) provided for the compulsory inclusion of chiropractic services under the State's Medicaid (Title XIX) program. Following extensive consideration of this bill in committee it was reported "do not pass."

In the Senate, S.B. 24, a bill to require insurance companies to extend their coverage to include chiropractic "treatment" remains as a live bill. No conclusive action was taken on this bill by committee. **MAG OPPOSED BOTH CHIROPRACTIC BILLS VIGOROUSLY.**

Institutional License—Under present law certain medical practitioners (aliens) are given institutional licenses which permit them to practice medicine in a State institution, under supervision of an M.D. in possession of a full and valid license. H.B. 437, introduced at the request of the governing authority of the hospital at Fort Oglethorpe, Georgia, sought to extend the privilege of an institutional license down to the level of the hospital authorities. MAG opposed this bill. However, it was reported favorably from committee but never called up for a vote in the House. It remains as a live bill and could be voted on at the 1970 session.

Exempt Blood From Implied Warranties—Last year (1968) the General Assembly passed a bill to exempt from the provisions of implied warranties under the Uniform Commercial Code, the use of blood and blood derivatives for transfusions. The Governor vetoed this bill.

A modified version drawn to meet the specific objections of the Governor was introduced at the 1969 session and was favorably reported from committee. It was never acted on by the House, but remains a live bill and will be "pushed" at the '70 term of the Legislature.

Fluoridation—Senate Bill 82, a bill to require all municipalities of 5,000 population and greater to fluoridate their public water supply was introduced and reported favorably from committee. MAG supported this bill in line with its long standing policy in favor of fluoridation. However, the bill was defeated on the floor of the Senate.

Venereal Disease Treatment—MAG sponsored and secured passage of a bill to permit a physician to treat a minor for venereal disease without the consent of the minor's parents. The physician would have

the prerogative of advising the parents of the child's condition or withholding this information as he sees fit to do. (Bill not yet signed by Governor as of date of this writing.)

Joint M.D.—Osteopath Examining Board—H.B. 655, a bill to create a Joint Board of Examiners for medicine and osteopathy was introduced with the support and endorsement of MAG. The bill provided for the following main points:

(1) That the Board of Osteopathic Examiners would cease to function after December 31, 1970, and would not issue any new licenses upon passage of the composite board bill.

(2) That two osteopaths would be added to the Board of Medical Examiners.

(3) That we would create two distinct classes of osteopaths: those with full practice privileges and those with restricted privileges. In the case of new applicants, passage of the examination given by the Board of Medical Examiners (FLEX) and conformity with all other requirements of the Board imposed on both medical and osteopathic graduates without distinction, would gain full practice licensure. In the case of those osteopaths presently holding an osteopathic license, the Board would issue a full practice license upon exhibiting evidence of having completed postgraduate courses to be conducted by the Medical College of Georgia and Emory University School of Medicine. Those presently licensed osteopaths who elect not to participate in these postgraduate courses would receive a limited license that prohibits the practice of obstetrics or surgery other than the minor suturing of cuts. Otherwise his practice would be limited to the extent that he was practicing osteopathy as of the date of passage of the Composite Board bill. The existing Board of Osteopathic Examiners would retain the power to determine the nature and extent of the practice engaged in on the date of passage of the bill.

(4) That the Board of Medical Examiners be given the power to enjoin anyone for the illegal practice of medicine.

(5) That the Board of Medical Examiners would have the power to determine the good standing of medical and osteopathic schools.

This bill passed the House and was favorably reported by the Senate Health and Welfare Committee. The Rules Committee placed the bill on the calendar one day, withdrew it the following day and rejected by a vote of 6 to 5 efforts to have it placed on the calendar again in order that it may be called for a vote by the full Senate. It remains a live bill and can be called up next year.

This bill presented special problems for your Legislative Committee. It was the first time in memory that the medical profession has been so divided on an issue it was presenting to the General Assembly. Traditional friends of the profession in the Senate were perplexed. A mild credibility gap was produced and the presence of spokesmen for the medical profession "lobbying" opposite sides of the same issue created conditions that will not well serve medicine's best interest on other bills.

RECOMMENDATIONS

Your Legislative Committee is most aware of the responsibility that Council has for legislative affairs

between meetings of the House of Delegates. It is also mindful of the superb job Council has done in this respect over the years. However, in an effort to prevent a serious split as the Joint Board bill created this year, your Committee recommends that all parties (Council, Executive Committee, Legislative Committee, county medical societies, individual members) pledge themselves to the concept of "going that extra mile" to accommodate the views and objections held by any significant group within MAG—that whenever humanly possible MAG present a united front to the public and to the Legislature on matters of public policy.

COMMENDATIONS

Your Legislative Committee would like to thank the Educational Committee of the Georgia Society of Ophthalmology and Otolaryngology for the valuable assistance it provided to the MAG legislative program through the effective help of its Secretary, Mrs. Talitha M. Russell.

It would also like to acknowledge the services furnished by Mr. John Moore and other members of the legal firm of Alston, Miller and Gaines.

Again, as is the case year after year, we have seen demonstrated the absolute necessity of having Mr. Jim Moffett on the job daily at the Capitol during the legislative session. We appreciate his tireless efforts in our behalf and offer our highest commendations.

DOCTOR-OF-THE-DAY

For the first time, MAG set up and staffed with volunteer physicians and nurses a dispensary at the Capitol during the 1969 session of the General Assembly. It proved to be immensely popular with the members of the House and Senate. It was sanctioned by the Speaker of the House and the Lt. Governor. Your committee wishes to thank all those who participated as volunteer physicians and pay special tribute to them as providing the best State level legislative public relations yet undertaken by MAG. It is anticipated that we will provide this service again next year.

REFERENCE COMMITTEE RECOMMENDATION—Your committee approves the report of the Committee for State Legislation and commends this committee for its diligent services and its innovative character. The reference committee would like to bestow special commendations for the implementation of the very successful "Doctor-of-the-Day" program at the State Capitol and recommends continuation of this program.

HOUSE OF DELEGATES ACTION—Adopted the reference committee recommendation as presented.

Occupational Health

TOM HOWELL, M.D., *Chairman*

The Occupational Health Committee met in September 1968 and primary discussion was related to changes in the Workmen's Compensation standards. The committee also reviewed the proposed Federal Health and Safety Act of 1968. This bill did not receive action during the 1968 session but will certainly be reintroduced during 1969. Of additional interest is a proposal by Senator Jacob Javits that a commission be

appointed to study the entire scope of Workmen's Compensation Laws.

The Occupational Health Committee would like to suggest continued efforts toward raising the schedule of payments in Workmen's Compensation injuries to the level of usual and customary fees. An attempt should be made to offer active assistance to the Workmen's Compensation Board in obtaining a more concise method of reporting and billing industrial injuries. Mr. Sam Caldwell, Labor Commissioner, should be advised that the appropriate committees of the Medical Association will be glad to assist in rendering any service as regards to occupational health, etc.

REFERENCE COMMITTEE RECOMMENDATION—The report of the Committee on Occupational Health is approved.

HOUSE OF DELEGATES ACTION—Adopted the reference committee recommendation as presented.

Physician-Lawyer Liaison

J. FRANK WALKER, M.D., *Chairman*

The Physician-Lawyer Liaison Committee, after a recess of several years, met September 7, 1968, at the time of the Medical Association of Georgia Committee Conclave.

The meeting was jointly chaired by Judge George Fryhofer, vice-chairman of the Bar Committee on Liaison.

Unanimous was the decision to update the Inter-professional Code of Cooperation adopted by the Georgia Bar Association and the Medical Association of Georgia in 1957. A procedure in this regard was adopted. Comments relative to changes are now being received by the respective professional groups.

We anticipate another meeting at the time of the Medical Association of Georgia Annual Session in Savannah, the home of the Bar Chairman, Mr. Ogden Doremus.

REFERENCE COMMITTEE RECOMMENDATION—Your committee approves this report and takes special note of additional information supplied by the chairman that a new code of cooperation between medicine and law will be forthcoming at the next meeting of Council.

HOUSE OF DELEGATES ACTION—Adopted the reference committee recommendation as presented.

School Child Health

FRED L. ALLMAN, JR., M.D., *Chairman*

The functions of the School Child Health Committee of the Medical Association of Georgia during the past year have been to stimulate cooperation by individual physicians in the School Child Health Program; to keep the profession informed on School Health Problems; to encourage sanction by the medical profession of a sound school health program and to report to the profession on progress. Our committee has improved its relations with the dental society, school system, Health Department, parent groups, Georgia High School Association, and other appropriate organizations.

Specifically, the Committee has accomplished the following:

(1) Follow-up of existing projects:

(a) Smoking and Health: The Teacher Resource Kits which were placed in the schools in 1967 in cooperation with the State Department of Education, the Georgia Heart Association, the Georgia Tuberculosis Association, the Georgia Cancer Society, and the State Health Department have continued to be utilized in many schools throughout Georgia and have been used as a model for other States.

(b) The Medical Association of Georgia through the Committee on the Medical Aspects of Sports of the School Child Health Committee again sponsored a post-graduate course on the Medical Aspects of Sports. Members of the committee, other members of the Medical Association of Georgia, athletic trainers from the University of Georgia and Georgia Tech, joined with Dr. Martin Blazina, orthopaedic surgeon and team physician for U.C.L.A. athletic teams, and John E. Roberts, Executive Director of the Wisconsin Interscholastic Athletic Association in presenting a very interesting and worthwhile program.

Again, the highlight of the meeting was a luncheon which was co-sponsored by the Health Department under the supervision of Mrs. Mary Helen Goodloe and the Florida Citrus Commission. More than 100 coaches and physicians attended the luncheon and participated in an informal discussion on "Nutrition for the Athlete."

(c) The committee has continued in its efforts to have "The American Medical Association Guide for Medical Evaluation for Candidates for School Sports" made available to all participants of athletic teams in schools throughout our State and that the forms contained therein be the minimum information furnished for each candidate for an athletic team.

(d) The committee has continued to cooperate with the Georgia Interagency Council on School Child Health. It is hoped that the Medical Association of Georgia will continue to send a representative of our committee to this very worthwhile Council.

(e) Representatives of this committee served on the planning committee for the Second Annual Youth Conference on Smoking and Health. Three hundred and sixty-three high school seniors from 83 counties and 153 communities of our State attended this meeting in Atlanta, September 20 and 21.

(f) Classification of Students for Physical Education—The committee continued its efforts to formulate an acceptable form that will be suitable for all physical education programs throughout the State.

(2) New Projects Completed During the Year:

(a) An article prepared by this committee and prefaced by Dr. Robert Greenblatt, concerning the potential danger of Androgenic drugs, appeared in the July issue of the *Journal of the Medical Association of Georgia*.

(b) The committee issued the following statement to the Georgia School Food Service Association, Inc. regarding the School Lunch Program:

"Adequate nutrition is essential to good health, which in turn is necessary for the mental alertness required in learning. The school lunch program is vital

in meeting the nutritional needs of many children, and therefore should be considered an essential part of the educational system."

(c) Uniform College Health Record Forms—After reviewing many forms the committee has selected the one prepared by the Liaison Committee of the American Medical Association and the American College Health Association as the form which should be recommended for the colleges of our State.

(d) The committee has formulated "Guidelines for Pre-adolescent Participation in Sports" and plans wide distribution of the guidelines through such organizations as community recreational departments, the Y.M.C.A., etc.

(3) Future Projects:

(a) The Medical Aspects of Sports Conference will be held again this year in Macon. All physicians and coaches are urged to attend this meeting which will be held early in August.

(b) A questionnaire is to be mailed to all schools in the State to inquire as to the type and extent of medical care given to their athletes. This questionnaire is to be devised in cooperation with Mr. Sam Burke, Executive Secretary of the Georgia High School Association.

(c) Annual distribution, to all schools, of the *JMAG* article "Heat and the Athlete" has been recommended to the Georgia High School Association by the Committee.

(d) Pre-school screening of vision and hearing—The Committee has reviewed the vision and hearing screening program of the Minnesota State Medical Association and feels that this is a very worthwhile program. The committee is also cognizant of the time, effort, planning and organization necessary to conduct such a program successfully. Further investigation and study of this plan in conjunction with the Georgia Society of Ophthalmology and Otolaryngology, Georgia Academy of Pediatrics and other interested groups should be encouraged.

(e) Drug Abuse—Increased usage of dangerous and harmful drugs by school children necessitates the institution of educational programs for physicians, teachers, parents and pupils. The committee hopes to cooperate with other health agencies in promoting such an education program.

(f) School Benefit Plans—The committee has reviewed the benefit plan of the Wisconsin Interscholastic Athletic Association and others and realizes the advantages and disadvantages of such plans. We feel that in the future such a plan may be necessary for our State in order that good medical care might be economically financed for all athletes and pupils. We therefore propose to continue that study and would like for the Insurance and Economics Committee of the *MAG* to look into the establishment of criteria for school insurance.

(g) The unprecedented number of deaths (six) in Georgia during a single football season in 1968 requires an evaluation of health and coaches' practices, especially in our high schools throughout the State. Although our State was among the first to conduct meetings on the medical aspects of sports, it is obvious that the information is not reaching the "grass roots."

Two proposals are offered in an effort to overcome this "information gap." The first is to urge the State

Board of Education and the Georgia High School Coaches Association to establish certification requirements for coaches. Such a certification would require minimum standards of instruction in important subjects such as first aid, health, and other preventive measures. It would also require periodic attendance at meetings concerning the medical aspects of sports.

Secondly, meetings similar to our annual Medical Aspects of Sports meeting might be held in some of our smaller communities. These meetings would be organized in such a way that physicians, parents, coaches and school administrators would become more knowledgeable about the health of athletes. Several private business organizations representing the milk, poultry and soft drink business have expressed an interest in contributing funds to finance such a program.

In concluding the report I would like to recommend that citations be given to Mrs. Mary Helen Goodloe of the Georgia Department of Health and to Dr. Virginia McNamara. Both of these individuals have given freely of time and self and their service and assistance to this committee have been invaluable.

The committee would like to urge each member of the Medical Association of Georgia to help develop the integrated relationship of health and education.

There can be no question that one needs to be educated in order to develop and protect one's health, and one needs abundant health to make full use of one's education. It is a reciprocal and actual relationship that deserves the attention of every physician in Georgia.

REFERENCE COMMITTEE RECOMMENDATION—
Your committee approves with high commendation the report of the Committee on School Child Health.

HOUSE OF DELEGATES ACTION—Adopted the reference committee recommendation as presented.

Separate Billing

DONALD R. ROONEY, M.D., *Chairman*

The Separate Billing Committee met on September 8, 1968, in Atlanta. Business discussed included:

(1) Reviewal of history and purposes of the committee.

(2) Dr. R. Finnegan stated that anesthesiologists' fees were being paid by Blue Cross rather than Blue Shield, and requested that we confer with Blue Shield officials. This has since been done and Mr. James of Atlanta Blue Shield reports that if a hospital-based physician such as an anesthesiologist, radiologist or pathologist sends his own statement for his services, separate from the hospital bill, Blue Shield will pay these physicians. In the case of some anesthesiologists' bills, they are paying about 80 per cent. They now have in the planning stage "Paid in full" Blue Shield contracts which may help.

(3) There have been instances where a few physicians just completing residency training have signed percentage contracts. They stated they never heard of any AMA or MAG policy on this matter. It was suggested that lectures on this matter be offered to residents in training. This has been done since then, for radiology residents in Atlanta and Augusta. This committee has offered help to five hospital-based spe-

cialists wishing to initiate separate billing and to 10 others already billing separately.

(4) Dr. Paul Scoggins stated that it is difficult to insist on separate billing by hospital-based physicians in smaller Georgia cities when some physicians at Emory and Grady Hospital merge their fees with the hospital bill. No action has been taken on this matter since others in MAG are looking into it.

(5) Pressures are being generated toward physicians under contract to hospitals by the "Military Medicare" and Medicare programs which possibly could be alleviated by these physicians billing separately from the hospital. This is under study at the present time.

(6) Discussion on merging this committee with the Committee on Professional Conduct sometime in the future was held, but no action was taken.

(7) It was recommended that we contact the chairman of the MAG Annual Session requesting that a speaker be obtained for the 1969 Annual Session to discuss how to establish separate billing successfully. Horace Cotton was suggested. This request was made.

RECOMMENDATIONS

(1) Request that presidents of state specialty societies in anesthesiology, pathology, radiology, physical medicine and others having members in hospital-based practice, contact chiefs of service teaching resident physicians to offer a series of lectures dealing with AMA and MAG policy on merging the physician's fee with the hospital bill.

(2) Publicize in *The Journal of MAG* the unfortunate consequences of percentage contracts.

(3) Continue to offer help to those captive specialists wishing to initiate separate billing.

REFERENCE COMMITTEE RECOMMENDATION—
Your committee approves this report and recommends that the Separate Billing Committee in consultation with legal counsel draft a statement of policy regarding contracts for the medical staffing of hospital emergency rooms and that such letter be sent to all hospitals in order that they be made aware of MAG concern for percentage contracts and other appropriate purposes.

HOUSE OF DELEGATES ACTION—Adopted the reference committee recommendation as presented.

Awards

JOHN S. ATWATER, M.D., *Chairman*

The Committee on Awards of the Medical Association of Georgia was appointed by the president of the Association, has met, and its recommendations have been approved by the Council of the Medical Association of Georgia at their regular meeting December 15, 1968.

Your committee has researched all available records regarding the establishment and purposes of each existing award. This was made possible by the fine effort of our associate executive secretary, Mr. James M. Moffett. Special gratitude is expressed also to Mr. Lamartine G. Hardman, Jr., son of the late Honorable L. G. Hardman, former Governor of the State of Georgia, who provided copies of much pertinent material relative to the Hardman Award. A copy of the original presentation address given by the late Governor Hard-

man to the annual banquet of the Medical Association of Georgia on May 14, 1931, was included in the memorabilia.

Based on the foregoing research the following criteria to be observed in the selection of recipients of the Medical Association of Georgia awards to be presented at the Annual Session were approved:

(1) *General Practitioner of the Year*—This award is presented to an outstanding General Practitioner in Georgia. Selection of the recipient will be made by the House of Delegates from ballots cast during the first session of the House. The Georgia Academy of General Practice and component county medical societies are invited to make one or more nominations for this award. No nomination will be considered unless accompanied by supporting biographical data and received at the headquarters office of the Medical Association of Georgia at least two weeks prior to the opening of the Annual Session. No nominations for this award may be made from the floor of the House. The president of the Georgia Academy of General Practice will present this award at the final general session of the Annual Meeting.

(2) *Hardman Award*—This award is presented for "the achievement of anyone who in the judgment of the Association has solved any outstanding problem in public health or made any discovery in medicine or surgery," or such contribution to the science of medicine. The recipient of this award will be selected by a five-man secret committee. Nominations for this award are to be made by component county medical societies and all nominations must be accompanied by supporting biographical data and received by the headquarters office of the Medical Association of Georgia no later than two weeks prior to the opening of the Annual Session. If no nominations and supporting data are received, no award will be made. No nominations for this award may be made from the floor of the House. If given, this award will be presented at the final general session of the annual meeting. By custom this award has usually gone to a Georgia physician. However, this is not required by the terms of the letter from the late Governor Hardman establishing this award.



John Kirk Train, M.D. presents a sterling silver bowl to Richard Torpin, M.D., of Augusta, past recipient of the Hardman Award.



J. W. Chambers of LaGrange receives the Distinguished Service Award from MAG President Charles R. Andrews.

(3) *Distinguished Service Award*—The Distinguished Service Award is presented for distinguished and meritorious service which reflects credit and honor on the Association. Nominations for this award should be made by component county medical societies and must be received by the headquarters office of the Medical Association of Georgia no later than two weeks prior to the opening of the Annual Session. They must be accompanied by biographical data supporting the nomination. If no nominations and supporting data are received, no award will be given. The recipient will be selected by a five-man secret committee and presentation will be made at the final general session of the annual meeting.

(4) *Civic Endeavor Award*—This is a new award available for presentation for the first time at the 1969 Annual Session and will be given pursuant to an action taken by the 1968 House of Delegates in Augusta. This award is to be given for outstanding public service and participation in civic activities. Component county medical societies are invited to make nominations for this award, supported by appropriate data which must be received at the headquarters office of the Medical Association of Georgia at least two weeks in advance of the Annual Session. If no nominations and supporting data are received, no award will be given. The recipient of this award will be selected by a three-man secret committee who shall determine if the nominees meet the requirements of the resolution which created this award. Presentation will be made at the final general session of the annual meeting.

(5) *Certificates of Appreciation*—The Committee on Awards will make recommendations to Council as to whom Certificates of Appreciation should be given. The Council of the Medical Association of Georgia retains the prerogative to add such names to this list as they deem wise. The Committee on Awards did not favor the automatic giving of Certificates of Appreciation to retiring committee chairmen unless, in the



State Representative Virgil T. Smith accepts a special Certificate of Appreciation from Earl T. McGhee, M.D., of Dalton.

opinion of the committee or Council, such chairmen have performed good and deserving work. The committee points out consideration for these Certificates of Appreciation might well be extended to non-medical groups or corporations who have made outstanding contributions to medicine.

The action of the Committee on Awards was approved further by Council at their regular meeting in Gainesville, Georgia on March 8, 1969, to the effect that all living previous recipients of the Hardman Award be presented with an engraved silver bowl commemorating this award. Such presentation would be made in person (or through an appropriate alternate representative) by the president-elect of the Medical Association of Georgia at the final session of the annual meeting. Funding and purchase of these bowls for previous recipients was approved by Council at the Sea Island, Georgia meeting September 14-15, 1968. It was requested further that all future recipients be given similar silver bowls and that expenses for the bowls and engraving be provided out of the general funds of the Association.

RECOMMENDATIONS

(1) Since definite clear-cut criteria have been established, it is recommended that such criteria be publicized thoroughly through appropriate announcements in the *Journal of the Medical Association of Georgia* and the Officers' News Letter in the January and March issues each year prior to the usual annual sessions.

(2) It is recommended that members of the Association make available nominations, where appropriate, not only of physicians but of those outside of medicine per se in order to give recognition to those who have supported the goals and ideals toward which we strive.

(3) It is recommended that each year the president of the Association appoint a Committee on Awards

maintaining as much continuity and rotation of members as to provide continued interest and stimulus to the Association members to search out and make appropriate nominations for these deserving awards.

REFERENCE COMMITTEE RECOMMENDATION—Your committee feels a particular commendation should be bestowed upon this committee for the clear, concise criteria established for the selection of recipients of awards given by MAG.

HOUSE OF DELEGATES ACTION—Adopted the reference committee recommendation as presented.

Resolution 69-1

TRAINING OF FAMILY PHYSICIANS

Irving D. Hellenga, M.D., Toccoa

WHEREAS, there is a dire shortage of family physicians in Georgia; and

WHEREAS, the primary purpose of the tax-supported Medical College of Georgia should be the training of doctors to care for the sick and injured citizens in Georgia; and

WHEREAS, at the present time there is no facility in the Medical College of Georgia with this as its primary purpose; now

THEREFORE BE IT RESOLVED, that the Medical College of Georgia implement immediately a meaningful and comprehensive program of training in family care in its Department of Community Health; and

BE IT FURTHER RESOLVED, that a copy of this resolution be sent to the secretary of each component medical society of the Medical Association of Georgia and that it be read to the local society at its next meeting; a copy be sent to each member of the Board of Regents; a copy be sent to each member of the Georgia Legislature; and a copy be sent to the Governor of the State of Georgia.

REFERENCE COMMITTEE RECOMMENDATION—Your committee recommends approval of this resolution with an amendment to change the second where-as to read: "WHEREAS, the primary purpose of the tax-supported Medical College of Georgia, and the Emory University School of Medicine should be the training of doctors to care for the sick and injured citizens in Georgia; and"; and also, to change the word "health" in line 13 to the word "medicine."

HOUSE OF DELEGATES ACTION—Adopted the reference committee recommendation as presented.

Resolution 69-3

CHANGES BROUGHT ABOUT BY REAPPORTIONMENT OF DISTRICTS IN THE UNIT ORGANIZATION OF DISTRICT MEDICAL SOCIETIES

Laurens County Medical Society

WHEREAS, after much consideration and consultation with other district societies we conclude that the effectiveness of the district societies has been greatly diminished by the change from medical and geographical areas to congressional districts. In some sections there has been a decided decline in interest and at-

tendance simply due to distance and lack of referral contact with the group to which they are now assigned.

WHEREAS, we think the district societies should be organized so there will be as full a participation and interest as possible. Medical interest should be primary and political interest secondary.

THEREFORE BE IT RESOLVED, that the MAG House of Delegates be requested to consider these points and recommend to the MAG that the district societies be reorganized on medical and geographical and not a congressional basis.

REFERENCE COMMITTEE RECOMMENDATION—Your committee recommends disapproval of this resolution based on its judgment that the present district system now used is more practical and also for lack of what it felt was an acceptable alternative.

HOUSE OF DELEGATES ACTION—Speaker Rogers recognized Delegate J. Frank Walker of Fulton County who moved that the recommendation of the reference committee not be adopted, and that the resolution as introduced be referred to Council for further study. The motion was unanimously adopted.

Resolution 69-6

POLICY ON CHIROPRACTIC

Fulton County Medical Society

WHEREAS, The United States Supreme Court has upheld the right of a State to refuse to license chiropractors unless they meet the same educational standards required of medical practitioners; and

WHEREAS, The United States Supreme Court in upholding the opinion of the U.S. District Court at New Orleans held, in effect, that the Equal Protection Clause of the Fourteenth Amendment to the United States Constitution does not bar any State from requiring chiropractors to have medical degrees as a means of protecting the health of its citizens; and

WHEREAS, No chiropractic school is accredited by any recognized educational accrediting agency in the United States; and

WHEREAS, Doctor of Chiropractic degrees (D.C.) are listed as "spurious" by the U.S. Office of Education in a recent publication entitled "Academic Degrees"; and

WHEREAS, The Department of Health, Education and Welfare in an extensive, thorough report issued in December 1968 to the Congress, such report having been prepared pursuant to an in-depth investigation requested by the Congress, has recommended that chiropractic services not be covered in the Medicare program for reasons that relate directly to their lack of competency to render quality health care;

NOW THEREFORE BE IT RESOLVED, That the House of Delegates of the Medical Association of Georgia adopt the following statement as its official policy regarding the cult of chiropractic:

Statement of Policy

It is the position of the medical profession that chiropractic is an unscientific cult whose practitioners lack the necessary training and background to diagnose and treat human disease. Chiropractic

constitutes a hazard to rational health care in the United States because of the substandard and unscientific education of its practitioners and their rigid adherence to an irrational, unscientific approach to disease causation.

In 1965, a United States district court, in upholding a state's constitutional right to refuse to license chiropractors, said that "since chiropractic claims to be a complete and independent healing art capable of curing almost all kinds of disease, the State legislature may have felt that the requirement of a foundation in materia medica and surgery . . . would be a protection to the public." Without dissent, the United States Supreme Court affirmed the decision.

The wisdom of these decisions by the nation's highest courts justifies the medical profession's educational program of alerting the nation to the public health threat posed by the cult of chiropractic.

Patients should entrust their health care only to those who have a broad scientific knowledge of diseases and ailments of all kinds, and who are capable of diagnosing and treating them with all the resources of modern medicine. The delay of proper medical care caused by chiropractors and their opposition to the many scientific advances in modern medicine, such as lifesaving vaccines, often ends with tragic results.

AND BE IT FURTHER RESOLVED, That this statement of policy be publicized in the *Journal of the Medical Association of Georgia* and made available to the public press in an effort to alert the members of the profession and the general public to the cultist nature of chiropractic.

REFERENCE COMMITTEE RECOMMENDATION—Your reference committee recommends approval of this resolution as a much needed statement of policy.

HOUSE OF DELEGATES ACTION—Adopted the reference committee recommendation as presented.

Resolution 69-8

DIRECT BILLING UNDER MEDICAID

Fulton County Medical Society

WHEREAS, Federal law does not prohibit direct billing of Medicaid patients by physicians, and

WHEREAS, this system is already in operation and approved by HEW in the State of Massachusetts,

THEREFORE BE IT RESOLVED, that this House of Delegates formally request the State Board of Health to implement the policy of direct billing of patients in the Georgia Medicaid program by September of 1969.

REFERENCE COMMITTEE RECOMMENDATION—This resolution which formally requests the State Board of Health to implement a policy of direct billing of Medicaid patients in Georgia was reviewed in light of regulations governing the operation of this program as enunciated by the Department of Health, Education and Welfare. Accordingly, the committee amended line 8 of the resolution to delete the words "by September of 1969" and insert in lieu thereof

the words "when feasible." As explained to the committee, current regulations would not permit direct billing. However, the above amendment will serve to notify the Board of Health of the MAG position on this matter at such time as it can be implemented. Your committee recommends approval of this resolution as amended.

HOUSE OF DELEGATES ACTION—Speaker Rogers recognized President Charles R. Andrews, Jr., who explained that a "choice of billing" of Medicaid patients in Georgia might be the more desirable request to make of the State Board of Health. With the consent of the House, reference committee chairman Davis changed the reference committee report by deleting the word "direct" in the first sentence and inserting the words "choice of," making the first sentence of the reference committee recommendation read, "This resolution which formally requests the State Board of Health to implement a policy of choice of billing of Medicaid patients in Georgia was reviewed in light of regulations governing the operation of this program as enunciated by the Department of Health, Education and Welfare." Chairman Davis then added a new second sentence, "The reference committee recommends changing line seven of the resolution by deleting the word "direct" and inserting in lieu thereof the words "choice of." The House then adopted the reference committee recommendation as amended.

Resolution 69-9

AMENDMENTS TO MEDICAL PRACTICE ACT TO PRESCRIBE STANDARDS FOR THE LICENSING OF OSTEOPATHS TO PRACTICE MEDICINE

Fulton County Medical Society

WHEREAS, the protection of the patient is our first concern in all medical matters, and

WHEREAS, the maintenance of two standards of medical care is not in the best interest of the patient, and

WHEREAS, osteopaths have indicated an interest in qualifying to practice medicine, and

WHEREAS, organized medicine should develop a constructive position on the question of single licensure for all persons practicing medicine which would protect the patient.

THEREFORE BE IT RESOLVED that the following amendments to the Medical Practice Act are hereby declared to be the official policy of MAG, such amendments to be introduced at the January, 1970 session of the General Assembly:

(Preamble Omitted)

BE IT ENACTED BY THE GENERAL ASSEMBLY
OF GEORGIA:

SECTION 1

Section 84-907 of the Code of Georgia . . . is hereby amended by striking said Section 84-907 in its entirety and inserting in lieu thereof a new Section 84-907 to read as follows:

"84-907. *License to practice medicine; how obtained; qualifications of applicants.*

Any person wishing to obtain the right to practice medicine in this State, who has not heretofore been registered or licensed to do so by the State Board of Medical Examiners shall, before it shall be lawful for him to practice medicine in this State, make application to the State Board of Medical Examiners through the Joint Secretary, State Examining Boards, upon such form and in such manner as shall be adopted and prescribed by the Board, and obtain from the Board a license so to do. Unless such person shall have obtained a license as aforesaid, it shall be unlawful for him to practice, and if he shall practice medicine as defined in Section 84-906 without first having obtained such a license, he shall be deemed to have violated the provisions of this Chapter. All applicants for a license to practice medicine or for a renewal of any such license which has been revoked shall furnish the Board with evidence of good moral character. Applications from candidates to practice medicine or surgery in any of its branches shall be accompanied with proof that the applicant is a graduate of one of the two colleges of medicine now existing in the State of Georgia, or from some other legally incorporated medical college, osteopathic college, or institution approved or accredited by the American Medical Association and the Association of American Medical Colleges, and in good standing with the Board, provided, however, that nothing herein shall prevent the licensing of graduates of medical schools outside of the United States under such rules as the Board may promulgate.

"Any such graduate, either before or after completing a year's training as an intern as required by the next paragraph of this section, shall be eligible to stand any regular examination given by the Board for a license to practice medicine in this State. However, before such persons shall be eligible to receive a license to practice medicine in this State, he shall furnish the Board with satisfactory evidence of attainments and qualifications under the provisions of this section and the rules and regulations of the Board. Nothing contained in this section shall be construed so as to require a person who has previously passed an examination given by the Board for a license to practice medicine in this State to stand another examination.

"If the applicant submits proof that he has had one (1) year of training in an internship program approved or accredited by the American Medical Association and approved by the Board, and if he furnishes satisfactory evidence of attainments and qualifications under the provisions of this Chapter and the rules and regulations of the Board, he shall be eligible to receive a license from the Board giving him absolute authority to practice medicine in this State."

SECTION 2

Chapter 84-9 of the Code of Georgia of 1933 as heretofore amended is hereby amended by adding a new section to said Chapter to be known as Section 84-907.1 to read as follows:

"84-907.1—*License to practice medicine, licensed osteopaths.*—Any person who holds a valid license to practice osteopathy in this State on the effective date

of this Act shall be entitled to obtain a license to practice medicine under this Chapter by making application to the State Board of Medical Examiners in the manner prescribed by Code Section 84-907 and upon successful completion of any regular examination given by the Board for a license to practice medicine in this State, which examination shall be the same as that administered to applicants pursuant to Code Section 84-907 of this act; provided, however, that nothing herein shall be construed to require a person holding a valid license to practice osteopathy in this State on the effective date of this Act, to be a graduate of one of the two colleges of medicine now existing in the State of Georgia, or from some other legally incorporated medical college, osteopathic college or institution approved and accredited by the American Medical Association and the Association of American Medical Colleges, and in good standing with the Board or to submit proof that he has had one (1) year of training in an internship program approved or accredited by the American Medical Association and in good standing with the Board, as a prerequisite to the issuance of a license to practice medicine under this Section.

SECTION 3

Chapter 84-9 of the Code of Georgia, as heretofore amended, is hereby amended by adding a new section to said Chapter to be known as Section 84-907.2 to read as follows:

"84-907.2. *License to practice medicine; degree to which licensee is entitled.*—On all licenses issued by the Board after the passage of the this Act, the Board shall enter after the name of the licensee the degree to which the licensee is entitled by reason of his diploma of graduation from a professional school in good standing with the Board."

SECTION 4

Chapter 84-9 of the Code of Georgia of 1933, as heretofore amended, is hereby amended by adding a new section to said Chapter to be known as Section 84-907.3 to read as follows:

"84-907.3. *Licensee to show degree on stationery and displays.*—A licensee under this Chapter shall, in any letter, business card, advertisement, prescription blank, sign, or public listing or display of any nature whatsoever, designate the degree to which he is entitled by reason of his diploma of graduation from a professional school in good standing with the Board."

SECTION 5

Section 84-910 of the Code of Georgia of 1933 is hereby amended by striking said Section 84-910 in its entirety and by inserting in lieu thereof a new Section 84-910 to read as follows:

"84-910. *Medical colleges; good standing; power of Board over.* The Board of Medical Examiners shall be empowered to pass upon the good standing and reputation of any medical or osteopathic college. Only such medical or osteopathic colleges will be considered in good standing as possess a full and complete faculty for the teaching of medicine, surgery and obstetrics in all their branches, afford their students adequate clinical and hospital facilities, have adequate curricula as determined by the Board in its discretion; that fulfill

all their published promises, requirements and other claims respecting advantages to their students and the course of instruction; that exact a preliminary educational requirement equal to that specified by this Chapter; that require students to furnish testimonials of good moral standing; and that give advanced standing only on cards from accredited medical or osteopathic colleges. In determining the reputation of the medical or osteopathic college, the right to investigate and make a personal inspection of the same is hereby authorized."

SECTION 6

Section 84-911 of the Code of Georgia of 1933 is hereby amended by striking said Section 84-911 in its entirety and by inserting in lieu thereof a new Section 84-911 to read as follows:

"84-911. *Same; preliminary educational requirements; certificate to show.*—Each medical or osteopathic school or college in good standing with the Board of Medical Examiners shall have a minimum preliminary educational requirement of the completion of a two-year premedical college course."

SECTION 7

... Section 84-915 of the Code of Georgia is hereby amended by striking said section as amended in its entirety and by inserting in lieu thereof a new Section 84-915 to read as follows:

"84-915. *Issuance and renewal of licenses to practice. Duty of joint secretary to aid in prosecutions.*—The Board of Medical Examiners shall have authority to administer oaths, to summon witnesses, and to take testimony in all matters relating to its duties. Said board shall issue licenses to practice medicine to all persons who shall furnish satisfactory evidence of attainments and qualifications under the provisions of this Chapter and the rules and regulations of the board. Such license shall be signed by the president of the State Board of Medical Examiners and attested by the Joint Secretary, State Examining Boards, under the board's adopted seal, and it shall give absolute authority to the person to whom it is issued to practice medicine in this State. It shall be the duty of the joint secretary under the direction of the board to aid the solicitors in the enforcement of this Chapter and in the prosecution of all persons charged with violations of its provisions.

"All licenses to practice medicine shall expire on December 31 of each year and shall become invalid on that date unless renewed. The fee for renewal of all licenses issued under this Chapter shall be established by the Board, such fees to be commensurate with the costs of fulfilling the statutory duties of the Board as defined by this Chapter. On or before December 1, the joint secretary, State Examining Boards, shall mail to each person holding a current license to practice medicine a blank to be used in applying for renewal of his license and a statement of the fee. Upon receipt of the application and renewal fee, the joint secretary, acting under the direction of the State Board of Medical Examiners, shall be authorized to renew the license. Failure to apply for renewal of a license and to remit the renewal fee during the month of December shall not withdraw the right of renewal but the renewal fee, if submitted after December 31, shall be three (3) times the regular renewal fee."

SECTION 8

. . . Section 84-927 is amended by striking said Section 84-927 in its entirety and by inserting in lieu thereof a new Section 84-927 to read as follows:

"84-927. *Institutional licenses to certain persons.* Notwithstanding the foregoing provision, any person who is a graduate of a school accredited and approved as hereinbefore provided; and who is employed by the State of Georgia in any State operated institution or who is employed by any medical college in the State of Georgia approved by the State Board of Medical Examiners of Georgia, upon request of the superintendent of such State institution or the dean of such medical college employing said physician, may be granted an institutional license authorizing such physician to practice medicine in the State institution or medical college employing said licensee, under proper medical supervision, which institutional license may be renewed each 12 months so long as the licensee remains in the employ of the State institution or medical college requesting the license, at the sound discretion of the State Board of Medical Examiners: Provided, however, such institutional license shall not be *prima facie* evidence that the holder thereof meets the minimum basic requirements for examination by the State Board of Medical examiners or for the issuance of a permanent license to practice medicine."

SECTION 9

. . . Section 84-929 of the Code of Georgia is hereby amended by striking said Section in its entirety and by inserting in lieu thereof a new Section 84-929 to read as follows:

"84-929. *Injunction against illegal practices; petition by Board.* In addition to any other remedy or criminal prosecution, whenever it shall appear to the Board of Medical Examiners that any person or persons, firm, company, partnership, association, or corporation or their agents, officers, or directors is/are or has/have been violating any of the provisions of this Chapter, or any of the laws of the State of Georgia relating to the practice of medicine, said Board may, on its own motion or on the verified complaint in writing of any person, file an equitable petition in its own name in the superior court in any county of this State having jurisdiction of the parties, alleging the facts and praying for a temporary restraining order and injunction and a permanent injunction against such person or persons, firm, company, partnership, association, or corporation and their agents, officers and directors, restraining him, her, it, or them, from violating such law, and, upon proof thereof, the said court shall issue such restraining order, injunction and permanent injunction, without requiring allegation or proof that the petitioner therefore has no adequate remedy at law. No restraining order, or injunction, whether temporary, permanent or otherwise, shall be granted without a hearing after at least 10 days' notice. It is hereby declared that such violation or violations of the provisions of this Chapter is or are a menace and a nuisance dangerous to the public health, safety and welfare."

SECTION 10

Chapter 84-9 of the Code of Georgia of 1933, as heretofore amended, is hereby amended by adding a

new section to said Chapter to be known as Section 84-936 to read as follows:

"84-936. *Voluntary Sterilization Act; physicians with D.O. or Doctor of Osteopathy degree subject to provisions of.* Doctors of Osteopathy who are licensed by the State Board of Medical Examiners under Section 84-907 of this Chapter, as amended, or who obtain a license to practice medicine under Section 84-907.1 of this Chapter shall be subject to all the provisions of Section 84-931 through 84-935 of this Chapter, which sections are known as the Voluntary Sterilization Act. They shall have all the authority and immunity granted by said sections to physicians, surgeons or doctors of medicine and shall be subject to the same limitations and responsibilities."

SECTION 11

Chapter 84-12 of the Code of Georgia of 1933, as amended, is hereby further amended by adding a Section to be known as Section 84-1212 to read as follows:

"84-1212. *No further licenses under this Chapter after the passage of this Act.*—The Board of Osteopathic Examiners shall not, after the effective date of this Act, grant any new licenses for the practice of osteopathy to persons not validly licensed to practice osteopathy in this State on the effective date of this Act. Licenses in good standing under Section 84-1207 on the effective date of this Act may be renewed only under the provisions of Section 84-1207, as amended, upon payment of the fee in compliance with the requirements of that Section, and the State Board of Osteopathic Examiners shall remain in existence for the purpose of all other functions bestowed upon it by such Chapter except the examination of new applicants and the issuance of new licenses under such Chapter. No new licenses shall be granted by comity to licentiates of other States pursuant to the provisions of Section 84-1208 after the effective date of this Act."

SECTION 12

Severability. In the event any section, subsection, sentence, clause or phrase of this Act shall be declared or adjudged invalid or unconstitutional, such adjudication shall in no manner affect the other sections, subsections, sentences, clauses, or phrases of this Act, which shall remain in full force and effect, as if the section, subsection, sentence, clause or phrase so declared or adjudged invalid or unconstitutional were not originally a part hereof. The General Assembly hereby declares that it would have passed the remaining parts of this Act if it had known that such part or parts hereof would be declared or adjudged invalid or unconstitutional.

SECTION 13

Effective Date. This Act shall become effective immediately upon its approval by the Governor, or its becoming law without his approval.

SECTION 14

All laws or parts of laws in conflict with this Act are hereby repealed.

REFERENCE COMMITTEE RECOMMENDATION—
Your committee spent several hours hearing witnesses expressing support for and against this resolution. Considerable time was consumed in explanation

of H.B. 655, the bill to create a Joint Board of Medical Examiners (Medicine and Osteopathy), which has passed the House of Representatives of the State Legislature and is now pending in the State Senate. Following extensive debate and a full airing of positions, your committee recommends the following: That the House of Delegates accept H.B. 655 in its basic form with the following amendment: That the present osteopaths in Georgia, in order to obtain a full medical practice license from the State Board of Medical Examiners, must pass an examination given by the Board.

HOUSE OF DELEGATES ACTION—Speaker Rogers recognized Past President John T. Mauldin of Atlanta, who discussed the following proposed changes in the reference committee recommendation.

That the House of Delegates of the Medical Association of Georgia approve the form of House Bill 655 as passed by the House of Representatives provided the following amendments are made:

(1) Delete the references to the American Medical Association and the American Osteopathic Association in the determination of good standing of medical and osteopathic colleges and internship programs with the State Board of Medical Examiners.

(2) Require that the State Board of Medical Examiners shall adequately inspect each medical or osteopathic college not heretofore approved as in good standing with the State Board of Medical Examiners upon the basis that such colleges meet the standards of colleges heretofore approved as in such good standing.

(3) Require that the State Board of Medical Examiners shall evaluate or inspect medical or osteopathic internship programs not heretofore approved as in good standing with the State Board of Medical Examiners on the basis that such programs meet the standards of programs heretofore approved as in good standing with the Board.

(4) Provide adequate powers and financing for the State Board of Medical Examiners to make such evaluations and inspections.

(5) Provide amendments to current provisions allowing licensing by comity to require that the State Board of Medical Examiners only license by comity upon recognition of particular medical or osteopathic colleges and internship programs approved by it if the applicant graduated from such approved college and internship program after the date on which it was recognized as in good standing by the State Board of Medical Examiners.

Speaker Rogers then recognized Delegate J. Frank Walker, of Fulton County, who moved that the changes suggested by Dr. Mauldin be adopted as a resolution. Speaker Rogers then recognized Delegate Ollie O. McGahee, of Wayne County Medical Society, who proposed an amendment to the amendment as follows:

"Amend the proposed amendment to provide that the present osteopaths in the State, before receiving a full practice of medicine license would, after completion of the 36-hour course given by the two medical schools, be examined or evaluated by the State Board of Medical Examiners."

The amendment to the amendment was duly seconded and passed by a vote of 48 for and 36 against.

Speaker Rogers then called for the vote on the original question as moved by Dr. Walker, and the resolution was adopted by voice vote.

Dr. Watkins then reported that this concluded the report of Reference Committee No. 3 and moved for the adoption of his report as a whole as amended by the House of Delegates with appreciation to the members of his committee and staff for their time and effort and the diligence they demonstrated in considering the many items presented to them. This motion was duly seconded and approved.

Report of Reference Committee No. 4

James H. Manning, M.D., Chairman

(The following reports as presented to this reference committee are printed in full with the reference committee's recommendations and the action pursuant to them taken by the House of Delegates.)

Chairman Manning reported to the House that reports and resolutions referred to Reference Committee No. 4 were considered by the committee which met at 9:00 a.m., in the Winged Foot Room, Savannah Inn and Country Club on May 6, 1969. Members of the committee present included: James H. Manning, Marietta, Chairman; William E. Huger, Atlanta, Vice Chairman; Luther Vinton, Decatur; Billy S. Hardman, Gainesville; Alex P. Jones, Griffin; and James H. Smith, Rome.

Vice-Speaker, House of Delegates

PRESTON D. ELLINGTON, M.D., Augusta

As vice-speaker of the House of Delegates of the Medical Association of Georgia, my time and my services have been available to the speaker at all times during this past year to be used at his discretion in all matters concerning the House of Delegates.

I attended the Southeastern Speakers Conference in Atlanta on February 21-23, 1969. This conference is designed for the exchange of information and ideas.

Several innovations have been made this year in our House of Delegates which we hope will prove to be worthwhile and effective. Among these are the "loose leaf" handbook, the pre-registration of the delegates to eliminate the multiple registrations of the delegates in the past, and a reserved section with work tables for the delegates in the General Assembly room.

RECOMMENDATION

I recommend that the above changes be continued as long as they prove to be useful.

Your speaker and I will continue to seek means to further facilitate the work of the House of Delegates.

It has been my privilege to serve as vice-speaker of the House of Delegates this year.

REFERENCE COMMITTEE RECOMMENDATION—Your reference committee recommends approval with the comment that this committee finds the use of the loose leaf notebook to be very helpful and recom-

mends its continued use with the addition of dividers provided for use by the delegates in the loose leaf notebooks.

HOUSE OF DELEGATES ACTION—Adopted the reference committee recommendation as presented.

**DeKalb County Medical Society
Councilor and Vice-Councilor**

FLOYD R. SANDERS, M.D., *Decatur and*
M. F. SIMMONS, M.D., *Decatur*

All regular and called meetings of the Medical Association of Georgia Council held during the past year have been attended by one or both of us.

RECOMMENDATIONS

Due to the recent mass resignation of nurses at DeKalb General Hospital we have been deeply involved in the problems precipitated by this action. The offer of help as mediator made by the Medical Association of Georgia was greatly appreciated, but we suggest that consultation with either the councilor or representatives of the local medical society be considered before public entry by the Medical Association of Georgia into such a controversy. We would further recommend that the Medical Association of Georgia go on record as condemning the mass resignation tactic resorted to by members of the Georgia State Nurses Association in the recent trouble at DeKalb General Hospital; the disruption of patient care produced by such action is distinctly contrary to the public interest and is not in keeping with the high standards traditional in the nursing profession.

FOURTH DISTRICT MEMBERSHIP

Counties and Secretaries	Members December 31, 1968		Members December 31, 1967	
	MAG	AMA Dues Paying Only	MAG	AMA Dues Paying Only
DeKalb				
F. E. Morgan				
Decatur	197	180	181	160

REFERENCE COMMITTEE RECOMMENDATION—Your reference committee recommends approval of this report through line 12 with the amendment to the report as follows:

“Your reference committee recommends to the Medical Association of Georgia that it go on record as condemning any mass resignation tactics by the Georgia State Nurses Association. The disruption of patient care produced by such action is distinctly contrary to the public interest and is not in keeping with the high standards traditional in the nursing profession. The Medical Association of Georgia commends the DeKalb Hospital Governing Board on its action dealing with their recent controversy. It further recommends that all hospital governing boards establish mechanisms for direct access of all employees to the governing board. This is to preclude any blocks in the traditional line of communication.

HOUSE OF DELEGATES ACTION—Speaker Rogers recognized Delegate William W. Moore, Fulton County, who moved that the reference committee recommendation be amended by deleting the words

“the Georgia State Nurses Association” in the first sentence, and inserting in lieu thereof the words “nurses, physicians, and other professional personnel”; and that the reference committee recommendation be further amended by deleting the words “nursing profession” from the second sentence, and inserting in lieu thereof the words “these professions”; and that the reference committee recommendation be further amended by deleting the third sentence so that the recommendation would read: “Your reference committee recommends to the Medical Association of Georgia that it go on record as condemning any mass resignation tactics by nurses, physicians and other professional personnel. The disruption of patient care produced by such action is distinctly contrary to the public interest and is not in keeping with the high standards traditional in these professions. It further recommends that all hospital governing boards establish mechanisms for direct access of all employees to the governing board. This is to preclude any blocks in the traditional line of communication.” The amendment to the amendment was duly seconded and after considerable discussion, was adopted by a voice vote. The House then adopted the reference committee recommendation as amended.

Annual Session

PRESTON D. ELLINGTON, M.D., *Chairman*

The Committee on Annual Session of the Medical Association of Georgia wishes to express its sincere thanks to all those members of this association, to all those members of the auxiliary, to the Local Arrangements Committee, and to the staff of the Medical Association of Georgia for all their help in making this meeting possible. This year the committee has worked diligently to improve some areas of the annual meeting. Our objective always was to schedule the most informative, most interesting, most educational, and most effective meeting possible.

In our deliberations, a number of problems presented themselves. Among these were:

(1) “Poor attendance at the meetings.” The average physician attendance at our meeting has in the past several years averaged about 16 per cent of the membership in comparison with the national average for a State association of our size which is approximately 26 per cent attendance.

(2) “Poor attendance at some of the specialty scientific meetings.” Many times several interesting sessions have been held at the same hour, in either the same or different specialties. A person can attend only one at a time. Rather than spread these sessions so thinly, a concentration of topics of common interest and practicality, involving several specialty groups, would create more interest and would congregate more individuals in one place and at one time. We should perhaps abandon the time-honored shotgun presentation of diverse topics and present, instead, half-days devoted to “in-depth” concepts or “how-to” programs. Some specialty societies have scheduled pre-convention activities in the past, both business and scientific meetings, which many physicians attend and then depart even before the official registration of MAG opens. I feel that if these latter meetings were scheduled during the official dates of the MAG meet-

ing it would increase attendance and participation by these physicians in the MAG programs.

(3) "Lack of adequate meeting room accommodations." This has indeed been a problem during past meetings, but with the construction of more adequate convention facilities in most Georgia cities, we feel that this will be less of a problem in the future.

(4) "Inadequate pre-convention promotion of the meeting." This year several mailings have been sent to the membership concerning the meeting. Information has been published in the *JMAG* and several of the county medical societies bulletins; a special "slug" promoting the meetings was used in all mailings from the MAG office, and a printed "pocket" program was mailed to all members of the Association in advance of this meeting.

(5) "Inadequate incentives and diverse activities to encourage the members to attend." This year we have added many new features to the meeting in hopes of enticing more members to attend the meeting.

(6) "Too compact a meeting. No opportunity for flexibility."

(7) "Poor attendance at the President's Banquet." There were many other problems we encountered also, but in our attempt to solve some of them we have used as reference material:

(1) A really critical review of several of our past annual meetings.

(2) The format and programs of several other State medical association annual meetings.

(3) Several national meetings of various specialty societies.

(4) A review of two recent critical analyses of State medical association annual meetings.

As a result of these studies, we have made many changes in the format of our Annual Session. Several of these will be apparent at this meeting. Many others are planned for future meetings. According to our studies, the most successful State medical association annual meetings convene on a week-day. Because of

previous hotel commitments we were not able to apply this change for the 1969 meeting, but future meetings have been scheduled to convene on Thursday noon and adjourn the following Sunday noon.

The studies show that State medical association meetings that span a period of four days were the most successful in attendance and participation by the members. Therefore, this year we have lengthened the meeting to span four days instead of three days. This year we have a general scientific program scheduled for Monday afternoon and Tuesday afternoon. This has proven to be a more successful format rather than scheduling multiple scientific programs at the same time. The specialty societies have cooperated with us this year to the fullest extent possible, but because of previous speakers' commitments and the time element involved, we have not been able to effect this change to the extent desired. We have added several new incentives to this meeting which include the Physicians' Art Show, the tennis tournament, the Medical Mile, and others. We hope that these prove successful enough to be permanent additions to the Annual Session. We have added incentives for commercial and scientific exhibiting by increasing booth sizes when requested. We have attempted to improve the activities of the business sessions to attract better attendance and participation by the members. We have attempted to make the President's Banquet the "social highlight" of the session by many changes in the programming and by contracting for nationally recognized professional entertainment. By the increased time available to us at this meeting we have been able to schedule most activities in a way to eliminate overlapping and conflicting meetings.

The direction of the House of Delegates was to plan the Annual Session for several years in advance for several reasons, including the apparent ever-increasing demand for convention accommodations. The Annual Session Committee has reserved accommodations for the meeting on Jekyll Island for May 7-10, 1970 and for the meeting in Atlanta at the Marriott Hotel on May 13-16, 1971.

We have prepared a handbook which outlines the duties and the responsibilities of local arrangement committees which will be presented to the local arrangements chairmen which we hope will make their work easier.

We will prepare a dossier on each Annual Session for review by the committee and for future reference.

The Annual Session Committee will continue to try to improve further the annual meeting and will evaluate the results of this meeting on adjournment.

RECOMMENDATIONS

The Committee on Annual Session recommends that this format and programming as outlined in this report be continued for a period of at least five years in order that it may be properly evaluated.

REFERENCE COMMITTEE RECOMMENDATION—Your reference committee recommends approval with highest commendation for diligent research and effort.

HOUSE OF DELEGATES ACTION—Speaker Rogers recognized Delegate Robert Wells of Fulton County on a point of order to clarify the question of whether



Carl Aven, M.D., receives MAG's Civic Endeavor Award from J. Frank Walker, M.D.

a vote on an action in a later reference committee report would have the effect of superceding a vote on an item of business currently before the House. Dr. Wells explained that a recommendation contained in the report of the Annual Session Committee was also contained in the report of the Public Service Committee which will be included in the report of Reference Committee No. 5, and that it was his intention to introduce a motion based on the decision of the Chair on whether disapproval of the matter by the House when considering Reference Committee No. 5 recommendations would supercede passage of the Reference Committee No. 4's recommendation on the same matter. The Chair ruled that an action taken during the report of Reference Committee No. 5 recommendations would supercede an action taken on the recommendations of Reference Committee No. 4. The House then adopted the reference committee recommendation on the report of the Annual Session Committee as presented.

Woman's Auxiliary Advisory

W. C. MITCHELL, M.D., *Chairman*

The Chairman, as well as other members of the Advisory Committee, met with the president, Mrs. Hayward Phillips, and the members of her board at their organizational meeting. Their enthusiasm and eagerness to begin their business of "Unlimited Dimensions" permeated the atmosphere and one could not help but get the feeling of a desire to pitch in and help. I enjoyed the meeting and hearing the message of Mrs. C. C. Long, President of WA-AMA, at this meeting.

The amount of good work that these ladies do for our profession is astounding. This year, the Council has been fortunate to have Mrs. Phillips attend most of our meetings to give a report of their activities and to make at least a few members of MAG more knowledgeable of the Auxiliary functions.

I still do not believe the membership as a whole fully appreciates just what we have going for us and the potential we have left untapped by not taking more advantage of their efforts.



The Woman's Auxiliary of the Medical Association of Georgia staffed an information desk in the lobby of the Savannah Inn and Country Club.

RECOMMENDATION

I again urge that we have more joint committees with the Auxiliary which will save duplication of efforts, and create a joint commission to let the public know we do some good and do represent the greatest profession in the world. With their ready, willing, and available source of help we can shout it out loud and quit being so modest.

REFERENCE COMMITTEE RECOMMENDATION—
Your reference committee recommends approval of this report.

HOUSE OF DELEGATES ACTION—Adopted the reference committee recommendation as presented.

Blood Banks

LEE HOWARD, JR., M.D., *Chairman*

The Committee met September 7, 1968, in Atlanta and made several recommendations, one of which was the inspection of plasmapheresis centers by the Inspection Service of the Georgia Department of Health, which is currently inspecting clinical laboratories throughout the State.

It was also recommended that the Laboratory Division of the State Health Department establish standards and training programs for transfusion services for the State.

These two items have been referred to the Department of Health.

REFERENCE COMMITTEE RECOMMENDATION—
Your reference committee recommends approval with additional recommendation that the Committee on Legislation of the Medical Association of Georgia be instructed to prepare and propose legislation requiring the plasmapheresis centers operating in the State of Georgia to be required to have Georgia license with inspection by the Department of Public Health.

Due to the urgency of this problem the Committee on Legislation, in conjunction with the Committee on Blood Banks, should report its findings and recommendations at the earliest possible date to the Medical Association of Georgia Council.

HOUSE OF DELEGATES ACTION—Adopted the reference committee recommendation as presented.

Hospital Activities

ALEX P. JONES, M.D., *Chairman*

The Hospital Activities Committee has met on several occasions to consider resolutions of the House of Delegates, problems which have occurred between medical staffs and hospital governing boards and ways and means in which this committee could be of assistance to the physicians and hospitals in this State. Representatives from the Georgia Hospital Association attended the open meetings of this committee, which has led to a closer understanding and cooperation between the two organizations as each endeavored to bring about better patient care.

The resolution of the House of Delegates to require the appointment of a physician to the governing boards of hospitals was considered and it was felt that no

legislation should be sought to require a specific appointment of a physician to a hospital board. If such legislation was introduced, other groups could seek specific appointments by the same legislation. The number of physicians being appointed on hospital boards has been increasing and the Georgia Hospital Association has been encouraging voluntary appointments of physicians to hospital boards. The new standards of accreditation of the JCAH will probably contain a strongly worded recommendation that a physician be appointed or elected to hospital boards.

The House of Delegates resolution calling for permanent staff appointments was also considered and before action or recommendation could be made, an inquiry was sent to JCAH to be sure that the recommendations of this committee would not conflict with the accreditation standards. The JCAH was of the opinion that permanent staff appointments would be acceptable as long as there was a mechanism for annual review of clinical work of such appointees included in the Constitution and Bylaws of the medical staff. This committee felt that any medical staff seeking to change to permanent staff appointments for their senior staff members should include in their Constitution and Bylaws provisions and procedures for discipline and review of clinical work of each member. The medical staff must accept the responsibility for discipline and be willing to discipline its members. In order to be of help, this committee is preparing suggested provisions which should be included in the Constitution and Bylaws of a staff seeking the inclusion of permanent staff membership.

There has been an increase in the amount of paper work and non-medical work being required of physicians so that there has been a general concern as to how this load can be lessened. A sub-committee was appointed to study the use of computers and automated equipment in the hospitals and a standardization of hospital records. An inquiry was made to the JCAH regarding the use of computers or automated equipment and their opinion was that their use was acceptable as long as the physician indicated by signature or initials the accuracy of the document or individual identification keys were used. This committee continues its study and will report later.

The chairman attended a meeting in Chicago to study the new recommended Standards of Accreditation for hospitals as proposed by the JCAH. There was little disagreement over the principles and standards as proposed but there was a considerable amount of objection over the interpretations as presented. There is to be a meeting in the future to consider changes in these interpretations now being prepared by the JCAH.

Every hospital in the State of Georgia should be encouraged to seek accreditation. Plans are being made to use a sub-committee which will seek to establish teams to encourage and assist hospitals seeking accreditation. It is planned that there be teams of physicians and hospital representatives in every geographic area of the State with supervision of the sub-committee of this committee.

Several hospital medical staff disputes were submitted to this committee and all were resolved in some manner. This committee has standard criteria which must be met before the consideration of these disputes

or before mediation will be attempted. If there is to be success in mediation, both parties of the dispute must submit a request to this committee in writing. All mediation attempts will consist of a member of this committee, a physician at large and a member of the GHA, all of whom must be agreeable to both parties.

The main difficulty between hospital boards and staffs has been lack of communication and clear picture as to their relationship to each other as members of the health care team. The committee is preparing a statement which will be issued jointly by the MAG and GHA and will attempt to relate the jurisdiction and responsibility of each and their relationship to each other.

At a recent meeting of the committee, kidney dialysis for Medicaid patients was discussed. The committee found that renal dialysis and kidney transplants are an acceptable treatment for certain forms of kidney disease and should not be considered a unique form of medical care. The members recommended that necessary steps be taken to include these in established programs of medical care.

Title XIX review as a committee function was considered at the same meeting and it was stressed that all MAG members must accept responsibility for justification for the hospitalization of Medicaid patients. The committee members agreed to accept the assignment of Title XIX hospital review if requested to do so by the MAG Executive Committee.

RECOMMENDATIONS

(1) The Hospital Activities Committee should be continued in its expanded form so as to allow the use of sub-committee in specific areas of concern.

(2) The sub-committee on charting, automation and computers should be continued in order to allow continuation of study in an ever changing field.

(3) The sub-committee on accreditation of hospitals and every member of the MAG should encourage every hospital in the State to seek accreditation from JCAH.

(4) Disputes between hospital boards and medical staffs should be referred to this committee in writing with both parties requesting mediation.

(5) Permanent staff appointments should be sought on local levels with adequate discipline provisions and annual review of clinical work prescribed in the staff Constitution and Bylaws.

(6) The appointment or election of a physician to hospital boards should be encouraged through local voluntary effort rather than legislation.

(7) The Georgia Hospital-Medical Council should not be re-activated, as this committee serves in the capacity of the former Council.

(8) This committee should continue to work closely with the Georgia Hospital Association since they are concerned with the same problems.

(9) Efforts should be made to combine the Medicare and Medicaid forms into one form for simplicity and ease of processing.

(10) Necessary steps should be taken to include renal dialysis and kidney transplants in established programs of medical care.

REFERENCE COMMITTEE RECOMMENDATION—
Your reference committee recommends approval with highest commendation.

HOUSE OF DELEGATES ACTION—Adopted the reference committee recommendation as presented.

Supplemental Report 69-1

HOSPITAL ACTIVITIES

ALEX P. JONES, M.D., *Chairman*

JCAH STANDARDS FOR HOSPITAL ACCREDITATION

The Medical Association of Georgia would like to express its appreciation and thanks to the Joint Commission of Accreditation of Hospitals for inviting and permitting its participation through the chairman of the Hospital Activities Committee in the discussion of the provisional draft of the Standards for Hospital Accreditation. It is apparent that there was a great deal of thought and work by the Joint Commission in the preparation of this document, but as was apparent at the meetings from comments by State medical societies and State hospital associations, much more editing and evaluation needs to be done by the JCAH. Although we were assured that this would be done with legal consultation, the Medical Association of Georgia would like to make some general observations about the provisional draft with intentions to submit a word-by-word, line-by-line comment at a later date.

First, we would like to compliment the JCAH on the efforts to bring about a more coherent, cooperative team approach to the provision of medical care for the hospitalized patient through the involvement of the medical staff, governing board, executive officer and the departmental heads in the total care of the patient. The emphasis on the provision of total patient care through medical staff self-discipline, total involvement of the members of the hospital-medical care team and the extension of hospital care, into now often neglected parameters as desirable goals will provide a stimulus to those who provide medical care in hospitals.

Along with the Georgia Hospital Association, the Medical Association is concerned that the new standards are too specific in many areas without allowing the hospital-medical team an opportunity to meet patient needs in a manner which would be better adaptable to the community needs and availability. Many of the standards are desirable but are impractical because of lack of funds or necessary personnel. The extension of the JCAH activities into areas which are not concerned with patient care will have a tendency to detract from the primary goal of the JCAH, the patient and his care while in the hospital. Many of the standards and interpretations are repeated and often are in conflict with each other and some are in conflict with local or State laws.

With the approval of the House of Delegates of the Medical Association of Georgia, the following general remarks are submitted for your consideration:

(1) Continuing education is a necessity for continual improvement of patient care, but should be a single standard and not be repeated in each section.

(2) All references to specific organizations as a

criterion for qualification, standards or procedures should be eliminated or modified with "or similar."

(3) A careful re-appraisal of codes and standards should be made to be certain that they will not be in conflict with local or State laws.

(4) All States, licensure agencies and localities have specific building and safety codes which must be met, and for the JCAH to enter into this field would detract from their primary purpose by necessitating longer and more complete inspections of hospitals.

(5) As a public institution the hospital must meet certain regulations concerned with fiscal policies and the JCAH would be entering a new phase not related to patient care by requiring certain fiscal procedures.

(6) Specific goals should be set for hospitals and medical staffs, but the method of meeting these goals, or the method for determining the extent these goals are reached should be left to the individual institutions.

(7) Specific methods for assuring the proper care of the patient should be left to the individual attending physician operating within the prescribed regulations of the medical staff with the approval of governing board.

(8) Medical staff committees should be determined by the medical staff and only the requirement for the review of patient care or operation should be prescribed in the standards.

(9) Hospital responsibility for the care of patients should not be extended beyond treatment the patient receives in the hospital and certainly should not be required to enter into many written agreements or the transportation of patients.

(10) Nursing care of patients should be paramount without emphasis on written or planning of that care.

(11) Desirable parameters of social work and physical therapy should be encouraged but cannot be required since funds and personnel are not readily available.

(12) No standard should be restrictive and neither should the interpretations, for they tend to prohibit the use of judgment and improved techniques.

Since hospitals vary in size and function, it is apparent that all standards and interpretations cannot be made to apply to all equally well. It would seem that JCAH should either divide the hospitals into size or function or establish varying degrees of compliance according to the size of the hospital. How can all hospitals be expected to meet the same standards or requirements except in the relationship to other hospitals of the same number of beds or function?

TITLE XIX

Since there have been a number of complaints about Title XIX (Medicaid), the Hospital Activities Committee would like to submit the following recommendations:

(1) That every member of the Medical Association of Georgia has the responsibility to the hospital and the patient by adequately documenting the reason for hospitalization so that payment can be made.

(2) That in cases where there are questions regarding the reason for hospitalization, the case should be reviewed by a utilization review committee of the medical staff.

(3) That the Hospital Activities Committee be utilized as a review committee in all cases where no

solution can be reached by a utilization review or direct contact with the attending physician.

(4) That efforts will be made to standardize Medicare and Medicaid forms into one form.

REFERENCE COMMITTEE RECOMMENDATION—
Your reference committee recommends that this report be sent to the JCAH with the following single amendment:

Page 2, Item Number 2, Lines 10 and 11—to read:

Item (2): "All references to specific organizations as a criteria for qualifications, standards or procedures should be limited to as few as possible to assure good patient care."

HOUSE OF DELEGATES ACTION—Adopted the reference committee recommendation as presented.

Maternal and Infant Welfare

EUGENE L. GRIFFIN, M.D., *Chairman*

This committee met four times in 1968. The committee studied in detail every maternal death from information available, as well as other matter pertaining to maternal and infant health in the State of Georgia. Major areas of activities are listed in brief.

LIVE BIRTHS AND BIRTH RATE

There were 86,469 live births in 1967, and the birth rate of 19.2 is the lowest in over 40 years. (Preliminary data indicate there were between 88,000 and 90,000 live births in 1968.) Hospital deliveries in 1968 reached a high of 93.3 per cent.

MIDWIFE ACTIVITIES

In 1967 there were 4,889 (5.7 per cent) live births delivered at home by midwives. This was 846 or 14.75 per cent less than the previous year. During this same year, 1,006 hospital deliveries were paid for by Medicaid (Title XIX).

The committee is well pleased with the steady increase in percentage of hospital deliveries and a concomitant steady decrease in midwife deliveries. It is our sincere hope that by proper use of Title XIX Georgia can reach the point where all deliveries will be performed in hospitals and by a properly qualified physician.

MATERNAL MORTALITIES

There were 28 maternal deaths in Georgia in 1967 out of a total of 86,469 live births. This gives a maternal death rate of 3.2 deaths per 10,000 live births. This is the lowest rate ever reported in the State. The rate in 1966 was 4.6 deaths per 10,000 live births which was the lowest ever reported up until that time. All of the 1968 figures are not yet completed so that a comparable figure is not yet available for that year.

BIRTHS TO UNWED MOTHERS

There were 9,984 live births to unwed mothers in 1967. Although this was a decline of 177 from the previous year, the rate was up from 113.7 (1966) to 115.5 (1967). It appears that the rate has continued to rise in 1968. Births to teenage and unwed mothers are now becoming a serious problem in the State, not only because of the increased foetal morbidity associated with these conditions, but also be-

cause of the very unhealthy social conditions into which most of these infants are thrust.

NUTRITION

Seventy-eight counties have surplus commodities available and 80 have food stamp programs. Troup is the only county in the State without any such program available.

THERAPEUTIC ABORTION

On April 12, 1968, the Therapeutic Abortion Act became law. Seventy-three therapeutic abortions were reported, as required by law, to the Director of the Department of Public Health in 1967. Forty-eight were performed for maternal indications, 23 for fetal indications and two for rape. Most of these were performed in large centers. A more complete analysis of therapeutic abortion will be completed at a later date and presented to the physicians of the State.

FAMILY PLANNING

The Committee has given active support to local and statewide family planning programs. The intrauterine contraceptive device has been well received in the State program. The State data collection computerized evaluation system indicates there were 20,502 women actively participating in the State Health Department program as of December 31, 1968. This estimate is based upon proven, continuous active contraceptors by current records. The number is conservative as it does not include a large number who received service before instituting the current record system, and who may well be continuing. An amendment to the 1966 law entitled "The Family Planning Services Act" now permits services and supplies to be made available to anyone requesting such services and supplies. A significant drop in births in the birth order of six and beyond may be attributed to a large extent to the increased use of family planning.

CERVICAL CANCER SCREENING PROGRAM

The committee has actively supported the establishment and conduct of a statewide cervical cancer screening program sponsored by the Georgia Department of Public Health. The program offers Pap smears to indigent and medically indigent patients in maternal health clinics in local health departments. From February 1, 1967, through December 31, 1968, 28,769 Pap smears were done. Three hundred and fifty-six Pap smears were classified as suspicious or positive, representing 324 patients. Follow-up is completed on 212 of these patients, showing 136 to be benign and 76 to be malignant. Of significance is the fact that 60 cases were diagnosed and treated for preinvasive and 16 were diagnosed and treated for invasive carcinoma of the cervix. One hundred and forty-six counties are participating in the State program. According to the most recent report of the United States Public Health Service Cancer Control Program, 43 per cent of the women in Georgia had a Pap smear in 1966. This percentage was exceeded by the District of Columbia with 65 per cent of the females examined in 1966.

PERINATAL MORBIDITY AND MORTALITY

In 1967 a subcommittee on Perinatal Morbidity and Mortality was reactivated under the chairmanship of

Dr. Malcolm Freeman. This subcommittee has contacted hospitals throughout the State to determine the number having Perinatal Study Committees with the purpose of fostering the activities of these committees in studying perinatal morbidity and mortality. The subcommittee has also developed a confidential medical report form which would become a part of the State birth certificate. This report form has been approved by the Maternal and Infant Welfare Committee as a whole, and it is hoped that this or a similar report form will be eventually incorporated into the birth certificate by the State Board of Health. (Georgia and Massachusetts are the only two States that require no report of supplementary medical information on their birth certificates.) Such information is needed to make continuing analysis of maternal and perinatal complications for the State as a whole and for individual localities.

STERILIZATION LAW

A modification of the 1966 Sterilization Law was introduced into the Georgia Legislature during February, 1969. This modification was very liberal, requiring only the permission of the patient and a consultation with one physician for any individual to be sterilized in the State. This committee requested that the State Association go on record as opposing such a liberal law and a statement of position and a more suitable law be drawn up by proper legal authorities and be presented at a later date. The Executive Committee of the Council approved this position and directed the legal authorities to draft such a law.

RECOMMENDATIONS

(1) That the Medical Association of Georgia and its members support a modification of the Sterilization Law of 1966. Such a modification should allow sterilization upon married as well as unmarried women with consent of spouse if available. If the spouse is not available after reasonable effort, without his consent provided the patient has been properly advised prior to the procedure. Sterilization should also be made available to minors and incompetents provided it is agreed upon by the nearest of kin or guardian and/or by suitable court hearings and proper medical consultations in all cases;

(2) That the Medical Association of Georgia encourage the State Board of Health to plan for the inclusion of the confidential medical report on the birth and stillbirth certificates;

(3) That the Medical Association of Georgia and the State Board of Health assist this committee in every way possible to accumulate and use meaningful data on perinatal morbidity and mortality;

(4) It is recommended that the Maternal and Infant Welfare Committee be charged with the responsibility for gathering and reporting data on therapeutic abortions; and

(5) It is recommended that a resolution be drawn by MAG stating that the need for family planning, especially among the indigent and medically indigent women in Georgia, is one of our greatest problems; and that physicians should emphasize this need and offer their services to meet this need and to support the efforts of the State and local Health Department Family Planning Program.

REFERENCE COMMITTEE RECOMMENDATION—Your reference committee accepts this report with highest commendation and would like to request clarification in the future with regard to the age distribution of percentages, with specific reference to Page 3 of the report, lines 17 and 18.

The committee approves with highest commendation the recommendations with the amendment in recommendation 5, Page 4 of the report, lines 30 and 31, to read:

"It is recommended that MAG state that the need for family planning, especially among the indigent and the medically indigent women in Georgia, is one of our greatest problems; and that physicians should emphasize this need and offer their services to meet this need and to support the efforts of the state and local Health Department Family Planning Program."

HOUSE OF DELEGATES ACTION—Adopted the reference committee recommendation as presented.

Nursing Liaison

CHARLES EBERHART, M.D., *Chairman*

This committee met twice in 1968 with representatives of the Georgia State Nurses Association.

The Liaison Committee of MAG, with the Georgia State Nurses Association, has drawn up a "Joint Position Statement on Nursing Practice" which has been approved by the appropriate bodies of each association. In brief, this statement urges the appointment of a representative committee in every health care institution or agency to determine and implement policies for carrying out procedures and solving problems related to nursing practice and other health disciplines.

The need for such planning is becoming more urgent as technical, scientific and medical advances bring about changes in the traditional areas of medical and nursing practice.

Two such joint statements have been approved and copies have been mailed to hospitals, nursing homes and community agencies. One is on "intravenous administration of fluids, blood and its derivatives, and drugs by registered nurses licensed to practice in the state of Georgia" and the other "The registered nurse and emergency resuscitative measures." The latter is also endorsed by the Georgia Heart Association, Georgia Hospital Association and the Georgia State League for Nursing.

The crux of both statements lies in the provisions that:

(1) The nurse has had special competent teaching and supervision in the technique;

(2) The nurse performs the technique upon order of a licensed physician or pursuant to standing procedures established by the agency; and

(3) The nurse has qualified for the procedure in the specific health care agency in which she is working.

The committee has no recommendations to make to the House of Delegates at this time.

REFERENCE COMMITTEE RECOMMENDATION—Your reference committee accepts this committee report with approval.

HOUSE OF DELEGATES ACTION—Adopted the reference committee recommendation as presented.

Woman's Auxiliary

MRS. HAYWARD S. PHILLIPS, *President*

"Auxiliary Horizons" is the theme with which we initiated our year's program; we are now experiencing "Horizon Achievements." Each county auxiliary selected its own horizon, giving special consideration to its community's needs.

The composite statewide picture of achievement shows an over-all emphasis on service which is really the foundation of our entire program. Of primary importance is service to our youth. To assist in the leadership and guidance of our boys and girls there have been special programs on venereal disease, sex education, drug abuse, safety in sports, safety in driving and instruction for baby sitters. Extensive programs in the area of health careers have acquainted our youth with opportunities available in health-related fields. Speakers, panel discussions, literature and special films were provided which helped guarantee the success of this part of our program.

With the realization that "Home Sweet Home" is frequently the scene of unnecessary accidents, doll houses which portrayed many home hazards were displayed in libraries and county fairs. Other displays were made of "look-alikes" showing both poisonous and non-poisonous plants and drugs. Printed instructions of antidotes for many types of poisons were sent home by nursery school and primary grade children.

Many auxiliaries participated in measles immunization, diabetes detection and testing for hearing and sight deficiencies.

Each of our county auxiliaries contributes to two educational funds:

(1) Our own William R. Dancy, M.D., Student Loan Fund, which has helped a number of students from our State receive a degree in medicine. Forty-five hundred dollars in five loans have been granted this year. The total value of the fund is slightly over \$40,000, most of which is on loan. Payments on loans and current contributions enable us to meet requests.

(2) We also make substantial contributions to AMA-ERF each year.

(3) In addition, some of our auxiliaries have scholarship funds for nurses.

Legislation has been of prime importance with more of our members becoming actively interested than during any previous election; interest in legislative matters continues at a high level.

Concern for our mentally-ill patients inspired one auxiliary to have an annual Christmas money tree. Monetary gifts used as tree decorations last Christmas totaled \$106 and were sent to Gracewood patients. Other auxiliaries cooperated in the "adopt-a-resident-of-Gracewood" plan, remembering the adoptee on special occasions with cards and small gifts. Patients at Central State Hospital were the recipients of many boxes of clothing and other items.

In far away Taipai, Taiwan, another hospital received a contribution of \$500 from one of our auxiliaries. This was used for badly needed physiotherapy equipment. Financial assistance has also been given to the Hospital Ship *Hope*.

Resulting from the interest of one auxiliary, a shelf in the library of the new Governor's mansion was secured and is reserved for books whose authors are

Georgia physicians and their wives. Recently a number of autographed volumes were taken to the mansion and presented at a dedication ceremony.

Only a few of our activities have received mention here. However, the achievements in entirety are numerous and varied. We request that you read our Auxiliary Annual Report for complete reports which you will find stimulating and informative.

We, the members of your Woman's Auxiliary, feel that our most important function is to assist you in every way possible—striving to help you maintain good public relations, making necessary social contacts and fulfilling our role in the community as your professional and personal ambassadors.

We want to express our appreciation for your understanding at all times and for the generous financial assistance given us this year which has enabled us to carry out our program more effectively. As we make plans for the months ahead there are several recommendations which we should like to submit to the House of Delegates for its consideration and, we hope, for approval.

RECOMMENDATIONS

(1) Continue to extend an invitation to our state president to meet with the MAG Council.

(2) Continue joint meetings of related committee chairmen of MAG and WAMAG.

(3) Continue the financial support of the Auxiliary in the amount of \$2,500 now included in MAG's 1969 budget.

(4) Secure for our Auxiliary a seal similar to that used by MAG at its meetings. (To be designed after our own seal and smaller than that of MAG.)

(5) At the annual convention, allot a sum to be used for flowers for Auxiliary functions. (\$250 which MAG now includes in its convention budget is for the banquet only. Our request would be a separate amount.)

REFERENCE COMMITTEE RECOMMENDATION—
Your reference committee recommends approval with highest commendation and also recommends that the Medical Association of Georgia include in the MAG budget the banquet expenses as a separate item and increase the budget from \$250 to \$350.

HOUSE OF DELEGATES ACTION—Adopted the reference committee recommendation as presented.

AMA Delegates

J. W. CHAMBERS, M.D., *Chairman*

JOHN ATWATER, M.D., *Atlanta*

PRESTON ELLINGTON, M.D., *Augusta*

J. FRANK WALKER, M.D., *Atlanta*

Again I am pleased to be able to report full representation of the Medical Association of Georgia at both meetings of the House of Delegates of the American Medical Association. The loyalty and conscientious service of your delegation to the House of Delegates of the AMA should be a source of pride to the Medical Association of Georgia. Each reference committee was completely and adequately covered and your delegation continued its traditional legislative breakfast meetings on two mornings during each ses-

sion of the AMA. House items of business which had been introduced were adequately discussed and action decided prior to your delegates being on the floor of the House. Also, full representation on the floor of the House was assured at all times by the presence of all delegates. A good index as to the activities and the variety of business which was brought before the AMA House both in San Francisco and in Miami during the year 1968 is indicated by the fact that your delegation heard 60 reports and 81 resolutions introduced and discussed in San Francisco at the June meeting and 33 reports and 59 resolutions heard and introduced in the meeting in Miami in December, 1968. Appropriate specific reports of discussions and actions will be given to your reference committee by the various members of your delegation for subsequent reporting to this House of Delegates.

Your delegation is also pleased to report that the American Medical Association officers and members of its House of Delegates have been advised that the Medical Association of Georgia will place the name of J. Frank Walker, M.D., in nomination for the office of Vice-Speaker of the House of Delegates of the American Medical Association at its meeting in New York in July, 1969. Dr. Walker's candidacy has been very favorably received by members of the House of Delegates of the AMA and various friends of Georgia throughout the nation, and we are extremely pleased with the progress of his campaign so far. We have every reason to believe that we will be successful in the campaign to elect J. Frank Walker, M.D., as Vice-Speaker to the House of Delegates of the AMA. Another index as to the effectiveness of your delegation, I believe, can be reflected by the fact that four members of your delegation have served in the past year either as chairmen or members of reference committees of the House of Delegates of the American Medical Association. One member of our association who is the delegate from the section on Internal Medicine, Carter Smith, M.D., and who sits with our delegation, has served also as a member of the Special Committee of the House of Delegates of the AMA, commissioned to study the modus operandi of the scientific sections of the American Medical Association, commonly referred to as the Quinn Committee.

Finally, Mr. Speaker, your delegation earnestly solicits suggestions, criticisms, and comments by our membership and by the members of this House either before the reference committee or by direct communication to the individual members of your delegation. Please be assured that your entire delegation will continue to strive to be of the greatest service to the membership of the Medical Association of Georgia. Please be assured that it has been both a privilege and a pleasure to serve during this past year.

REFERENCE COMMITTEE RECOMMENDATION—
Your reference committee recommends approval with highest commendation and pleasure that our delegation is so highly regarded by the American Medical Association.

HOUSE OF DELEGATES ACTION—Adopted the reference committee recommendation as presented.

Georgia Regional Medical Program

J. W. CHAMBERS, M.D., *Program Coordinator*

Since my last report to this House of Delegates approximately one year ago at your annual meeting, much has transpired in progress and developments in the Georgia Regional Medical Program. I am most appreciative personally of having an opportunity in the development and progress of this program in Georgia since its inception in January, 1967. The membership of the Medical Association of Georgia as well as the members of this House of Delegates have been kept informed of the progress and developments of this program for the past year, in particular through publications in the *Journal of the Medical Association of Georgia*, and more especially the issue of February, 1969. I would call your attention to a report in detail of the operation of projects of the Georgia Regional Medical Program in this issue. In this report I will not attempt to go into minute detail, but will be happy to appear before the reference committee to give more detailed reports on any phase of the program which the Reference Committee would like to have. In addition to this either the program director, Dr. J. Gordon Barrow, or myself have given a report to the Executive Committee and to each meeting of your Council as it has met in the past year.

At the local level as it involves the Georgia Regional Medical Program, I am pleased to report that local hospitals, involving almost 95 per cent of the total hospital beds in Georgia, are now participating in this program and have set up local advisory groups to help to plan and to carry out this program as it has been established up to now. There is a projected meeting of the local advisory groups to be held in Atlanta later this month as this report is being written at this time. These local advisory groups play a most important part in the ongoing activities and the program development in this region, and for that reason we stress their development and their activity as much as we do.

The most recent important single development in this program occurred in March, 1968, at which time an operational grant application was submitted to the National Advisory Council of the Regional Medical Program. This application, I am happy to say, was favorably received and in July of 1968 the Georgia Regional Medical Program was notified that \$1,416,777 in operational funds had been granted for the first of a three-year program for the Georgia Regional Medical Program. These funds will underwrite 15 initial research training and clinical projects for the Georgia Regional Medical Program. Details and subsequent project applications will be outlined to the reference committee in as much detail as they desire. I believe that it is of significance that the importance of continuing education can be noted in that of the 14 projects approved in the first operational grant, seven are in the area of continuing education. Half of the total funds granted are allocated to these seven projects involved in continuing education. Later in the year 1968, a second operational grant request to fund five additional projects which will supplement the first 14 was submitted, but no report on this application is expected until later. During these intervening months, under

the able leadership of Dr. J. Gordon Barrow, the Program Director and his staff, all of these programs are being implemented and set in motion as rapidly as is economically feasible to do. In addition to this, Dr. Barrow has expanded his core staff only as it has been necessary and wise. I am also happy to report that the quality of the staff has been excellent insofar as the people involved. In addition to these developments the Steering Committee, after the first intensive flurry of activity in planning, has in the last year reorganized the task forces to make them more broadly represented and more easily functional in their areas. In this process it has reduced the total number of task forces from 13 to seven. The task forces have continued to function effectively and most conscientiously in this program.

Finally, Mr. Speaker, I believe the rapid progress that has been made in the Regional Medical Program in Georgia can primarily be attributed to the participation and interest of the practicing physicians in this State. We still need to have some of our membership better informed as to the purpose and the progress of the Regional Medical Program and to solicit wider participation of the practicing physicians. Since this is an entirely new approach in the field of medicine, it must take some time. The members of this House can be of invaluable service in helping to disseminate information as it relates to this program throughout the State in their own component medical societies. Also, I believe it is evident that the insight and long-range planning of the Medical Association of Georgia and the leadership in our two medical schools along with the other participants in the Regional Advisory Group, which is the governing body over all of this program, is paying wonderful and remarkable dividends in helping to develop better medical care for our people throughout the State of Georgia.

REFERENCE COMMITTEE RECOMMENDATION—
Your reference committee accepts this report with highest commendation and again with pleasure notes that the Georgia Regional Medical Program has been cited and is being used as a model program throughout the country.

HOUSE OF DELEGATES ACTION—Adopted the reference committee recommendation as presented.

Resolution 69-5

NURSING EDUCATION

DeKalb County Medical Society

WHEREAS, there have been dramatic changes in Nursing Education in recent years, and

WHEREAS, involvement of organized medicine has been less than adequate in planning and implementation of the same, and

WHEREAS, we are concerned as to the quality and effectiveness of such education and practicality in real situations, and

WHEREAS, each nurse in Georgia acts under direct authority of and responsibility to the individual practicing physician in patient care,

THEREFORE BE IT RESOLVED THAT, the Medical Association of Georgia cause to be formed such committees as necessary to inform itself as to present nursing school curricula and further evaluate

each of the types of schools as to its practicality and effectiveness in producing diplomates skilled in personal patient care, and

FURTHER BE IT RESOLVED THAT, such study be presented to this body sufficiently prior to the next Annual Session so that it might make effective recommendations to responsible parties.

REFERENCE COMMITTEE RECOMMENDATION—
Your reference committee recommends approval of Resolution No. 5.

HOUSE OF DELEGATES ACTION—Adopted the reference committee recommendation as presented.

Resolution 69-7

STUDY OF HOSPITAL MEDICAL STAFF ORGANIZATION AND OPERATION, BY MAG

Richmond County Medical Society

WHEREAS, physicians must admit their most seriously ill patients to hospitals for proper medical care, and

WHEREAS, physicians organized as the medical staff of a hospital must function efficiently and effectively to provide good medical care and to give proper guidance to the governing boards of such hospitals, and

WHEREAS, the organizational activities of the medical staff require a great expenditure of time and energy on the part of the medical staff, and

WHEREAS, the medical staffs of many hospitals are not able to meet their increasingly complex responsibilities adequately under current conditions of organization and operation,

THEREFORE BE IT RESOLVED, that the Medical Association of Georgia shall institute a study of hospital medical staff organization and operation, and

BE IT FURTHER RESOLVED, that upon the completion of this study, the Medical Association of Georgia shall make recommendations for improvement of hospital medical staff organization and function, and

BE IT FURTHER RESOLVED, that the Medical Association of Georgia shall develop a program to provide continued advice and assistance to the medical staffs of hospitals in Georgia.

REFERENCE COMMITTEE RECOMMENDATION—
This reference committee disapproves adoption of this resolution. Because of the already deep involvement of the Committee on Hospital Activities in this area and the forthcoming proposed manual by JCAH, which will also cover this area, we recommend that proposed resolutions be referred to the Hospital Activities Committee.

HOUSE OF DELEGATES ACTION—Adopted the reference committee recommendation as presented.

Chairman Manning then reported that this concluded the report of Reference Committee No. 4, and moved for the adoption of his report as a whole by the House of Delegates with appreciation to the members of his committee. This motion was duly seconded and approved.

Report of Reference Committee No. 5

T. J. Anderson, M.D., Chairman

(The following reports as presented to this reference committee are printed in full with the reference committee's recommendations and the action pursuant to them taken by the House of Delegates.)

In the absence of Chairman Anderson, Charles G. Burton, vice-chairman, reported to the House that reports and resolutions referred to Reference Committee No. 5 were considered by the committee which met at 9:05 a.m., in the Pinehurst Room, Savannah Inn and Country Club, Savannah, on May 6, 1969. Members of the committee present included: T. J. Anderson, Atlanta, chairman; Charles G. Burton, Macon, vice-chairman; Phil C. Astin, Carrollton; T. N. Lumsden, Clarkesville; Spencer S. Brewer, Atlanta; and Jack A. Raines, Columbus.

First District Councilor

CHARLES E. BOHLER, M.D., Brooklet

As Councilor of the First District, I have attended all regular and called meetings of the Council of the Medical Association of Georgia.

I have attempted to keep all the component societies of the First District acquainted with actions of the Council.

FIRST DISTRICT MEMBERSHIP

Counties and Secretaries	Members December 31, 1968		Members December 31, 1967	
	MAG	AMA Dues Paying Only	MAG	AMA Dues Paying Only
Ogeechee River*				
L. E. Curry				
Metter	22	21	18	17
Burke				
C. G. Green				
Waynesboro	9	5	9	6
Emanuel				
C. E. Powell				
Swainsboro	9	7	9	7
Jenkins†				
W. W. Hillis				
Millen			3	3
Laurens				
Jaime Franco				
Dublin	42	20	40	19
Screven				
G. B. Hogsette				
Sylvania	5	5	5	5
Southeast Georgia				
G. P. Sassos				
Mount Vernon	23	16	25	18
Tri-County				
W. D. Fraser				
Hinesville	2	2	3	3
	112	76	112	78

* Ogeechee River formerly Bulloch-Candler-Evans.

† Jenkins has merged with Ogeechee River.

REFERENCE COMMITTEE RECOMMENDATION—
Your reference committee recommends the approval of the report of the First District Councilor.

HOUSE OF DELEGATES ACTION—Adopted the reference committee recommendation as presented.

Second District Councilor

J. D. BATEMAN, M.D., Albany

SECOND DISTRICT MEMBERSHIP

Counties and Secretaries	Members December 31, 1968		Members December 31, 1967	
	MAG	AMA Dues Paying Only	MAG	AMA Dues Paying Only
Colquitt				
R. E. Fokes				
Moultrie	16	14	15	14
Decatur-Seminole				
M. A. Ehrlich				
Bainbridge	17	9	18	10
Dougherty				
Allen Turner				
Albany	60	47	60	47
Grady				
S. L. Hancock				
Cairo	5	4	5	5
Mitchell				
A. A. McNeill				
Camilla	6	6	7	6
Southwest Georgia				
R. E. Jennings				
Arlington	12	10	13	12
Thomas-Brooks				
D. J. McKenzie				
Thomasville	46	41	43	37
Tift				
P. W. Lucas				
Tifton	17	12	18	13
Worth				
R. T. Morgan				
Sylvester	5	5	5	5
	184	148	184	149

REFERENCE COMMITTEE RECOMMENDATION—
Your reference committee recommends the approval of the report of the Second District Councilor.

HOUSE OF DELEGATES ACTION—Adopted the reference committee recommendation as presented.

Third District Councilor

JOSEPH T. CHRISTMAS, M.D., Vienna

The Third District Councilor has attended all regular and called meetings of the Medical Association of Georgia Council during the past year except the June and December meetings which came at a time when it was impossible to attend. In addition to attending and participating in the meetings of the Council, the councilor has served as a liaison between the Council and the various component medical societies in the Third District by mailing each month the highlights of the Executive Committee meetings, and by contacting by telephone and letter the officers of the various Council meetings as the need arose.

There has been one county medical society in the Third District that was dropped from the active list of medical societies because of insufficient number of members. The Taylor County Medical Society's membership has dropped below five and the members of that society have been notified that the charter has been revoked and plans are being made now for those three members to merge with one of the adjoining societies.

There was one Third District Society meeting in October and a second Third District Society meeting was planned for the third Thursday afternoon in April.

THIRD DISTRICT MEMBERSHIP

Counties and Secretaries	Members December 31, 1968		Members December 31, 1967	
	MAG	AMA Dues Paying Only	MAG	AMA Dues Paying Only
Flint				
C. C. Goss				
Ashburn	17	14	13	10
Peach Belt				
F. B. Meserve				
Warner Robins	35	33	32	30
Randolph-Stewart-Terrell				
Mack Allen				
Dawson	14	11	14	11
Sumter				
W. R. Anderson				
Americus	22	18	21	17
Taylor				
E. C. Whatley				
Reynolds	3	2	3	2
	91	78	83	70

This list shows an increase of eight dues-paying members in 1968 over 1967.

REFERENCE COMMITTEE RECOMMENDATION—Your reference committee recommends the approval of the report by the Third District Councilor.

HOUSE OF DELEGATES ACTION—Adopted the reference committee recommendation as presented.

Sixth District Councilor

ERNEST E. PROCTOR, M.D., *Newman*

SIXTH DISTRICT MEMBERSHIP

Counties and Secretaries	Members December 31, 1968		Members December 31, 1967	
	MAG	AMA Dues Paying Only	MAG	AMA Dues Paying Only
Clayton-Fayette				
F. A. Sams				
Fayetteville	8	8	9	8
Coweta				
F. D. Bass				
Newnan	23	14	22	16
Lamar				
S. B. Traylor				
Barnesville	4	4	4	4
Meriwether-Harris				
J. L. Robinson				
Woodbury	14	12	14	12

Spalding				
Carlos Zevallos				
Griffin	41	36	42	37
Troup				
E. A. Prieto				
LaGrange	37	31	40	33
Upson				
J. E. Mikell				
Thomaston	18	15	18	15
	145	120	149	125

REFERENCE COMMITTEE RECOMMENDATION—Your reference committee recommends the approval of the report by the Sixth District Councilor.

HOUSE OF DELEGATES ACTION—Adopted the reference committee recommendation as presented.

Fulton County Medical Society Councilor

JOHN T. GODWIN, M.D., *Atlanta*

Councilor has attended all meetings, and has no recommendations.

FIFTH DISTRICT MEMBERSHIP

Counties and Secretaries	Members December 31, 1968		Members December 31, 1967	
	MAG	AMA Dues Paying Only	MAG	AMA Dues Paying Only
Fulton	1153	956	1099	904

REFERENCE COMMITTEE RECOMMENDATION—Your reference committee recommends the approval of the report of the Fulton County Medical Society Councilor.

HOUSE OF DELEGATES ACTION—Adopted the reference committee recommendation as presented.

Georgia Medical Society Councilor

LEE HOWARD, JR., M.D., *Savannah*

FIRST DISTRICT MEMBERSHIP

Counties and Secretaries	Members December 31, 1968		Members December 31, 1967	
	MAG	AMA Dues Paying Only	MAG	AMA Dues Paying Only
Georgia Medical Society				
J. J. Holloman				
Savannah	171	156	165	148

REFERENCE COMMITTEE RECOMMENDATION—Your reference committee recommends approval of the report of the Georgia Medical Society Councilor.

HOUSE OF DELEGATES ACTION—Adopted the reference committee recommendation as presented.

Traffic Safety

FLEMING L. JOLLEY, M.D., *Chairman*

The committee has been represented in public hearings relative to traffic safety legislation in 11 cities in November, 1968. With the Department of Health, the first state-level Emergency Medical Services Conference was held in Athens, Ga., December 1-4, 1968. Approximately 180 people were involved. Several

meetings involving local county societies, members of the American Red Cross, and Department of Public Safety officials have been held.

RECOMMENDATIONS

(1) County medical societies establish a local traffic or Emergency Medical Services Committee if such has not been done. An active committee can be an excellent public relations stimulant for that society. Involvement can include working with Georgia Safety Council for Teen-age Safety Clubs, instruction courses for ambulance and first aid groups to improve emergency care for the sick and injured.

(2) Consideration should be given to changing the name of the committee to Emergency Medical Services Committee. The AMA has a Commission on Emergency Medical Services and a Committee on Automotive Safety. The committee should be the Emergency Medical Services Committee, with Traffic Safety a subcommittee within the Emergency Medical Services Committee.

REFERENCE COMMITTEE RECOMMENDATION—Your reference committee recommends approval of the report of the Traffic Safety Committee with commendation.

HOUSE OF DELEGATES ACTION—Adopted the reference committee recommendation as presented.

Disaster Medical Care

VIRGIL B. WILLIAMS, M.D., *Chairman*

The chairman has been in correspondence with committee members as the need arose.

Liaison with State Civil Defense authorities has been maintained. This particularly concerns their promise of transportation and housing of physicians at major disaster scenes.

Close study has been made of all communications from AMA in reference to disaster medical care.

The chairman attended the Conference on Disaster Medical Care in Durham, N.C., on April 5-6, 1968. The chairman also attended the MAG Committee Conclave in Atlanta on September 1, 1968. At this meeting many aspects of Disaster Medical Care were discussed in depth.

The committee has been ready at all times to assist county societies in planning Disaster Medical Care Programs. Information concerning Disaster Medical Care Programs has been distributed to county societies requesting such.

REFERENCE COMMITTEE RECOMMENDATION—Your reference committee recommends approval of the report of the Disaster Medical Care subcommittee and also states that an active and effective emergency disaster plan is required by the Joint Commission for Accreditation of Hospitals. The committee feels that each physician should know his assignment in this plan and should work closely with hospital, Red Cross, civil defense, police and other agencies in emergency medical care.

HOUSE OF DELEGATES ACTION—Adopted the reference committee recommendation as presented.

Medicine and Religion

IRVING L. GREENBERG, M.D., *Chairman*

With relation to the Seminary program, Dr. Byron Harper and Dr. Homer Nash met with a representative of the Interdenominational Theological Seminary (Atlanta University) and they had a pleasant hour together. There was some indication that they might desire help in the future, that they were not just grasping for assistance at the present time. It was thought that some follow-up might be carried out at this institution.

Contacts with the Candler School of Theology at Emory University and Columbia Seminary are still in the process of being made. It is hoped there will be a discussion meeting arranged.

In addition, a program was arranged by Dr. Byron Harper on WAGA-TV (in Atlanta). Dale Clark, the TV interviewer, presented a program on "Ethics of Organ Transplants." Two clergymen, the Rev. Mr. James Dyer, Byron Harper's pastor, and Rabbi Sydney K. Mossman, who is Rabbi Emeritus of the Synagogue that I attend, met on a panel with Willis Hurst, M.D., Chairman of the Department of Medicine, and William D. Logan, Jr., M.D., Department of Thoracic Surgery, Emory University School of Medicine. This program went off very well and favorable comments about it were heard.

REFERENCE COMMITTEE RECOMMENDATION—Your reference committee recommends approval of the report of the Medicine and Religion committee with additional recommendation that active dialogue should be undertaken between the county medical societies and local ministerial associations regarding the field of organ transplantation and other areas of mutual concern.

HOUSE OF DELEGATES ACTION—Adopted the reference committee recommendation as presented.

Mental Health

JULIUS T. JOHNSON, M.D., *Chairman*

The Committee on Mental Health has met during the year, but attendance at the meetings has been somewhat disappointing. The majority of our time and effort has been spent in implementing the recommendations made last year and passed by the House of Delegates in May, 1968. Following through on trying to determine the extent and percentage of drug abuse in the State, the Mental Health Division of the State Health Department requested permission from the State Board of Health to include alcoholism and drug abuse on the list of reportable conditions from physicians. As of this time we have not received any statistical information on this topic.

In the area of physician education in mental health, our January meeting was devoted to a discussion of this. Dr. Joseph Baker, AMA Consultant on Mental Health, met with us. Dr. Baker outlined the programs of the AMA Department on Mental Health, including alcoholism, drug abuse, and physician education. After Dr. Baker's discussion, and a discussion of our efforts in the area of physician education, no further recommendations could be made over and above what was already being done. We have obtained a list of avail-

able speakers from the G.P.A. The past MAG staff representative, Mr. Wallace, had been very active in following up on requests from medical societies for a program in mental health; however, with his leaving, this activity temporarily has come to a halt.

The committee was asked to give an opinion on the bill introduced by the Psychological Association attempting to force insurance companies to include the services of practicing clinical psychologists under their health insurance plan. The committee was very much opposed to a non-medical service being paid for by health insurance. Also the question of clinical psychologists attempting to do psychotherapy without medical supervision has been an age-old problem and would be compounded by such legislation. The committee was very strongly opposed to this bill.

The committee decided to discontinue the Mental Health Page in the *Journal* for the present since the editor has resigned and the monthly page was not considered essential at this time.

There were two other bills proposed in the State Legislature concerning mental health; however, we will not comment on these since we were not asked for an opinion on these.

The committee continues to have a keen interest in the improvement and expansion of psychiatric treatment facilities in both the public and private sectors.

At this time there are no recommendations for consideration by the House.

REFERENCE COMMITTEE RECOMMENDATION—
Your reference committee recommends approval of the report of the Mental Health Committee.

HOUSE OF DELEGATES ACTION—Adopted the reference committee recommendation as presented.

Allied Health Careers

JOHN T. GODWIN, M.D., *Chairman*

The committee has continued to attempt to stimulate recruitment through the district councilors.

The Chairman has attended all meetings of the Health Careers Council of Georgia, Inc.

RECOMMENDATIONS

(1) There is continuing need for strong recruitment programs in the districts in an effort to fill the vacancies in the various schools over the State. It is recommended that the Council exert its influence in this effort.

(2) There is a need for the development of new categories of health personnel which requires the attention of those physicians in various specialties to define and delineate appropriate training programs.

(3) There is a need for closer relationship and discussion between physicians, health personnel and hospital administrations and it is suggested that intrahospital departmental committees, including appropriate categories of health personnel, meet frequently to discuss health care and personnel problems. It is recommended that the Council make this a first priority effort.

(4) The Committee thanks the Council for its financial support of the Health Careers Council.

REFERENCE COMMITTEE RECOMMENDATION—
Your reference committee recommends approval of the report of the Allied Health Careers Committee with additional recommendation that the committee on Allied Health Careers study the problem of licensure relative to each category of allied health personnel and report to the House of Delegates in 1970 with respect to any changes in existing procedures.

HOUSE OF DELEGATES ACTION—Adopted the reference committee recommendation as presented.

Public Service

TULLY T. BLALOCK, M.D., *Chairman*

It was the decision of the MAG Public Service Committee and the Annual Session Committee to include in the Annual Session program the same type of program which has been sponsored by the Public Service Committee in February for the past few years.

Arrangements were made for a County Society Officers Program on Tuesday, May 6, 1969, at the time of the Annual Session. Three county society officers discussed programs in their respective societies which have been of great interest and an inducement for better attendance. The "Medicine and Religion Activities in Cobb County" was discussed by Noah Meadows, M.D., Marietta. "A System of Coordinating Hospital Staff and County Medical Society Meetings" was the subject presented by William Huger, M.D., Atlanta, and "Building Attendance at County Medical Meetings" by Joe S. Robinson, M.D., Macon, was the third presentation.

RECOMMENDATIONS

The Public Service Committee would like to recommend that this type of program become an annual event at the time of the Annual Session.

REFERENCE COMMITTEE RECOMMENDATION—
Your reference committee recommends disapproval of the recommendation contained in this report, feeling that attendance at the county medical society program during the annual MAG session was very small and the scope of material which should be covered is too great for the brief time that can be allocated to such a program. Robert Wells, M.D., J. G. McDaniel, M.D. and Neal Yeomans, M.D. appeared before the reference committee and stated that in past years they felt the county society programs held in February were worthwhile and had better attendance.

HOUSE OF DELEGATES ACTION—Speaker Rogers pointed out to the House of Delegates that the recommendation of the reference committee was to disapprove the recommendation contained in this report, and that being the case, called for a specific action by the House on this particular recommendation of the reference committee. On motion duly made and seconded, the House of Delegates voted to sustain the recommendation of Reference Committee No. 5, which disapproved the recommendation contained in the report of the Public Service Committee.

Rural Health

T. N. LUMSDEN, M.D., *Chairman*

The Rural Health Committee of the Medical Association of Georgia met in July with its Advisory Council at the MAG Headquarters in Atlanta. First item of this meeting was the planning of the 4th Annual Health Conference jointly sponsored by the Medical Association of Georgia and the Georgia Farm Bureau in cooperation with the Extension Service of the University of Georgia. A tentative program was developed. After this other subjects of mutual concern were discussed. This Advisory Council has served a useful purpose in bringing together representatives from a cross section of organizations having an interest in the field of rural health in Georgia. It also helped to maintain liaison between the Medical Association of Georgia and Georgia Farm Bureau and the Extension Service of the University of Georgia. After the initial planning conference the necessary leg work was carried out for the promotion of the conference which was held at Rock Eagle Conference Grounds in October. A copy of this program follows:

Your Invitation to Attend the

"FOURTH ANNUAL GEORGIA RURAL HEALTH CONFERENCE"

Co-Sponsored by the Medical Association of Georgia and the Georgia Farm Bureau Federation in cooperation with the Cooperative Extension Service of the University of Georgia.

October 4-5, 1968
Rock Eagle 4-H Center
Eatonton, Georgia

FRIDAY AFTERNOON SESSION— UNION BAG BUILDING

October 4, 1968

- 11:30 A.M. *Registration*
- 12:00 NOON *Conference Luncheon—Dining Hall*
- 1:15 P.M. *Call to Order and Invocation*
Thomas N. Lumsden, M.D., Chairman
Medical Association of Georgia Rural Health Committee
Clarkesville
Mr. Cecil Johnson, Director
Rock Eagle 4-H Center
Eatonton
- 1:25 P.M. *Welcome*
Mr. William L. Lanier, President
Georgia Farm Bureau Federation
Macon
- 1:35 P.M. *Keynote Address*
J. Rhodes Haverty, M.D., Dean
School of Allied Health Sciences
Georgia State College
Atlanta
- 2:00 P.M. *Importance of the School Lunch*
Miss Josephine Martin
Food Service Department
State Department of Education
Atlanta
- 2:30 P.M. *Current Status of Rabies in the Southeast*
E. F. Baker, DVM, Asst. Chief
Rabies Control Center
Communicable Disease Center
Atlanta
- 3:00 P.M. *Break—Coffee, milk & rolls*

- 3:15 P.M. *Farm Safety*
Mr. Paul Crawford, Head
Extension Agricultural Engineering Department
University of Georgia
Athens
- 4:00 P.M. *Common Poisonous Plants*
P. E. Bostick, Ph.D., Asst. Professor of Biology
Emory University
Atlanta
- 4:30 P.M. *Recess*
- 6:00 P.M. *Conference Dinner and Entertainment—Dining Hall*
Entertainment by:
Hiawassee Blue Grass Band
FFA First Place String Band Winner
Hiawassee

SATURDAY MORNING SESSION— UNION BAG BUILDING

October 5, 1968

- 7:30 A.M. *Conference Breakfast—Dining Hall*
- 8:30 A.M. *Call to Order*
Thomas N. Lumsden, M.D., Chairman
Medical Association of Georgia Rural Health Committee
Clarkesville
- 8:35 A.M. *Community Action Workshop*
J. J. Lancaster, Ed.D., Head
Extension Education Department
University of Georgia
Athens
- 10:00 A.M. *Break—Coffee, milk & rolls*
- 10:15 A.M. *What One Community Has Done*
Thomas N. Lumsden, M.D., Chairman
Medical Association of Georgia Rural Health Committee
Clarkesville
- 10:45 A.M. *Award Winning Georgia 4-H Health Demonstration Project*
Rhonnie Bozeman
4-H Health Winner
Thomasville
- 11:00 A.M. *Traffic Safety Film*
- 11:15 A.M. *Conference Summary*
Mrs. L. T. Whitehead, Vice Chairman
Georgia Farm Bureau Women
Watkinsville
- 11:30 A.M. *Adjournment*
- 12:00 NOON *Conference Luncheon—Dining Hall*

In addition to working with the University of Georgia and Georgia Farm Bureau, the Rural Health Committee has cooperated closely with the Traffic Safety Committee of the Medical Association of Georgia in promoting programs of common interest for these two committees.

Medical Association of Georgia was represented at the 21st National Rural Health Conference held in Seattle in March, 1968 and will be represented at the 22nd Conference to be held in Philadelphia.

Following an invitation from the Medical Association of Georgia, the 23rd National Rural Health Conference will be held in Atlanta in 1971. This Committee of the Medical Association of Georgia will cooperate closely with AMA Council on Rural Health in planning and programming of this conference during the coming year.

REFERENCE COMMITTEE RECOMMENDATION—
Your reference committee recommends the approval of the report of the Rural Health Committee with commendation and with the additional recommendation that the Rural Health Conference be continued and be under sponsorship of the Medical Association of Georgia in cooperation with the Georgia Farm Bureau and the Extension Service at the University of Georgia.

HOUSE OF DELEGATES ACTION—Adopted the reference committee recommendation as presented.

Talmadge Hospital Liaison

PAUL T. SCOGGINS, M.D., *Chairman*

Relations of Talmadge Hospital and Richmond County Medical Society are, and have been, excellent this year. There has been no need for this committee to meet. We will stand by until needed.

REFERENCE COMMITTEE RECOMMENDATION—
Your reference committee recommends approval of the report of the Talmadge Hospital Liaison Committee.

HOUSE OF DELEGATES ACTION—Adopted the reference committee recommendation as presented.

Headquarters Building

J. G. McDANIEL, M.D., *Chairman*

As instructed by the House of Delegates and the Council, your Committee on the Headquarters Expansion program is moving along.

We were instructed to build an addition of 10,000 square feet on the present building, but to plan in the beginning for an additional 50 or 60 thousand square feet, or more, with adequate parking facilities should the future need arise.

At the present, we will build two sub-basement parking decks and one street level deck to extend under the addition of the building; the second floor will be the 10,000 square feet addition; the three parking decks will give us 145 parking spots, which will be adequate for the completed building. In the meantime, parking is critical in this particular area, and a nice income can be derived from renting the spaces.

Your Building Committee and the Executive Committee are quite optimistic. We firmly believe that the income from the addition to the building and the parking area will be adequate to retire the indebtedness of the project.

Prior to the 1968 annual meeting, preliminary discussions with several lending institutions had indicated that MAG would be able to secure both a construction loan and long term financing at an interest rate of approximately 6½ per cent. During the period of time between those discussions and the approval of the architects' proposal, the interest rate jumped a full percentage point which sent the entire financial market reeling. By the time the committee could begin seeking a definite commitment of money, most institutions were talking in terms of 7¾ per cent to 8 per cent.

A fortunate contact was made with the Decatur Federal Savings and Loan Association which resulted in our obtaining a 20-year combination loan with a

12-month take-out privilege and a maximum \$551,000 principal. The committee had hoped to obtain a \$600,000 loan toward the total cost of the contract of \$618,000, but since MAG's cash picture seemed favorable, the Decatur Federal Savings and Loan Association offer was accepted. We were able to save the expense of one entire closing, even though it was necessary to eliminate many of the refinements the committee had hoped to include. The Council at its meeting March 8-9, 1969, in Gainesville, directed the Headquarters Building Committee to add the necessary refinements identified at that time at a total cost of \$56,633 to the building contract, which was done.

Even in the face of weather delays the building is progressing nicely and the contractor has scheduled completion for September 29, 1969. Your Building Committee hopes that many members will visit the building site and see first hand the progress being made.

REFERENCE COMMITTEE RECOMMENDATION—
Your reference committee recommends the approval of the report of the Medical Association of Georgia Headquarters Building Committee with additional information presented by J. G. McDaniel, M.D., that the building will cost \$729,000 and will result in a deficit of \$153,000. The committee realizes that the Georgia Regional Medical Program is the prime tenant and that they rent on a year-to-year basis. The committee feels the property could be rented to other tenants provided the Georgia Regional Medical Program should discontinue its lease. The report was approved with commendation.

HOUSE OF DELEGATES ACTION—Adopted the reference committee recommendation as presented.

Resolution 69-4

CONTINUING EDUCATION FOR ALLIED HEALTH PERSONNEL

JOHN T. GODWIN, M.D., *Atlanta*

It is recommended that Allied Health Personnel be encouraged to have continuing education each year. This relates particularly to nurses, medical technologists, x-ray technicians and other technology classifications.

It is believed that individuals should provide the hospital or physician employer with evidence that there has been attendance at an acceptable continuing education program during the year. This could be on-the-job type refresher training, formal lectures, seminars, etc.

This program could be on a volunteer basis for the first year or so; however, it should become a requirement for consideration of continued employment, promotion, etc.

REFERENCE COMMITTEE RECOMMENDATION—
Your reference committee recommends the approval of Resolution No. 4 on the Continuing Education for Allied Health Personnel with the deletion of lines 10, 11, and 12. The reference committee feels that the Medical Association of Georgia should encourage continuing education of allied health careers, but should not itself regulate or enforce such continuing education.

HOUSE OF DELEGATES ACTION—Adopted the reference committee recommendation as presented.

Resolution 69-10

GaMPAC COMMENDATION

DeKalb County Medical Society

WHEREAS, the Georgia Medical Political Action Committee has demonstrated its ability to be effective in the election process in recent political campaigns at both the congressional and State House levels; and

WHEREAS, this organization continues to serve the best interest of the medical profession through its dual functions of political education and direct political activity; and

WHEREAS, GaMPAC membership continues to increase each year thus making possible its more effective involvement in direct political activity; and

WHEREAS, the second biennial GaMPAC Workshop is presently being planned for the fall of 1969 in furtherance of its role in the field of political education;

NOW THEREFORE BE IT RESOLVED, that the MAG House of Delegates reaffirms its support of the Georgia Medical Political Action Committee and urges all Georgia physicians and their wives to join voluntarily GaMPAC and partake of its programs in political education to the end that the best interest of patient care will be served through the election of sound and enlightened public officials.

REFERENCE COMMITTEE RECOMMENDATION—Your reference committee recommends the approval of the resolution of the Georgia Medical Political Action Committee with commendation.

HOUSE OF DELEGATES ACTION—Adopted the reference committee recommendation as presented.

Vice-Chairman Burton then reported that this concluded the report of Reference Committee No. 5, and moved for the adoption of his report as a whole by the House of Delegates with appreciation to the members of his committee. This motion was duly seconded and approved.

Speaker Rogers then called for unfinished business, and there being none, Dr. Rogers opened the floor for new business. There being no new business, Speaker Rogers thanked every member of the reference committees for his diligent work and the entire MAG office staff for their assistance, and entertained a motion for the adjournment of the Second Session of the MAG House of Delegates meeting in conjunction with the 115th Annual Session of the Association. On motion duly made and seconded, the House was adjourned at 12:45 p.m.

MAG General Session (Third Session)

115th Annual Session of the Medical Association of Georgia

Wednesday, May 7, 1969

THE THIRD GENERAL SESSION of the 115th Annual Session of the Medical Association of Georgia was called to order by Vice-President Fleming L. Jolley, Atlanta, at 9:20 a.m. in the Ballroom, Savannah Inn and Country Club, Savannah, Georgia, on May 7, 1969.

MAG Memorial Service

Vice-President Jolley led the session in tribute to those members who had died since the 1968 Annual Session. Following a reading of the 23rd Psalm, Dr. Jolley read the names of those departed colleagues as follows:

Memorial List

Wayne S. Aiken, Atlanta, October 2, 1968
 C. H. Allen, Bremen, September 18, 1968
 E. A. Allen, Atlanta, December 7, 1968
 J. F. Arthur, Columbia, South Carolina, May 10, 1968
 R. M. Avery, LaGrange, February 8, 1969
 R. A. Bartholomew, Atlanta, January 7, 1969
 L. S. Boyette, Ellaville, January 29, 1969
 Stephen T. Brown, Atlanta, January 2, 1969
 Warren F. Brown, Atlanta, February 19, 1969
 Eleanor E. J. Bundy, Decatur, February 17, 1969
 O. H. Cheek, Dublin, March 25, 1968
 J. A. Combs, Decatur, November 13, 1968
 Ernest Corn, Macon, August 26, 1968
 J. E. Davis, Atlanta, December 19, 1967
 Edgar F. Fincher, Atlanta, January 12, 1969
 Joseph E. Griffith, Marietta, April 3, 1969
 O. S. Gross, Vidalia, March 1, 1969
 W. W. Hillis, Sardis, October 19, 1968
 A. Robert Hornik, Jr., Augusta, March 17, 1969
 John S. Howkins, Savannah, December 19, 1968
 Harry Hutchins, Buford, February 1, 1969
 H. B. Jenkins, Donalsonville, October 25, 1968
 W. A. Johnson, Elberton, May 2, 1968
 Harry C. King, Griffin, December 31, 1968
 Seth E. Latham, Atlanta, July 18, 1968
 John Looper, Dalton, February 4, 1969
 L. F. Lovett, Statesboro, February 16, 1969
 J. Calhoun McDougall, Atlanta, June 26, 1968
 F. T. McElreath, Jr., Tennille, April 4, 1968
 V. H. McMichael, Macon, November 12, 1968
 M. R. McWhorter, Columbus, December 1, 1968
 H. W. Muecke, Waycross, October 26, 1968
 J. C. O'Neill, Savannah, November 23, 1968
 Hollis E. Puckett, Savannah, May 4, 1968
 W. E. Ragan, Atlanta, December 17, 1968
 Herbert F. Readling, Thomasville, November 11, 1968
 H. Y. Righton, Savannah, November 12, 1968
 Paul T. Russell, Albany, December 26, 1968
 H. C. Schenck, Atlanta, October 13, 1968
 Charles R. Smith, Columbus, September 2, 1968
 Henry C. Standard, Decatur, July 25, 1968
 Henry J. Tanner, Forest Park, June 10, 1968
 William Tanner, Young Harris, February 2, 1969
 J. Lowell Thomas, Rincon, September 11, 1968
 C. D. Whelchel, Gainesville, July 25, 1968

GP of the Year Award

President Andrews recognized Irving Hellenga of Toccoa, president of the Georgia Academy of General Practice, who presented the Medical Association of Georgia "GP of the Year Award" to Reuben S. O'Neal of LaGrange.

Civic Endeavor Award

President Andrews then recognized J. Frank Walker, president of the Fulton County Medical Society, who presented the first MAG Civic Endeavor Award to Dr. Carl C. Aven of Marietta.

Certificate of Appreciation

Dr. Andrews then recognized Earl McGhee of Dalton, who presented an MAG Certificate of Appreciation to Representative Virgil T. Smith of Whitfield County.

GaMPAC Awards

President Andrews recognized Earnest C. Atkins, Atlanta, chairman of the Georgia Medical Political Action Committee, for the purpose of presenting GaMPAC Awards. Dr. Atkins presented the award for reporting the highest percentage of GaMPAC members for 1968 to the Upson County Medical Society, making the second straight year that society has received this award. Dr. Atkins presented the GaMPAC award for the congressional district political action committee organization reporting the highest percentage of GaMPAC members to the Fourth District, also for the second year in a row. Dr. Atkins then presented the award for the largest dollar contribution made to GaMPAC by physicians and their wives from a county medical society to the Fulton County Medical Society.

Hardman Award

President Andrews announced that no nominations for the Hardman Award had been received from county medical societies for 1969, but that MAG wished to recognize past recipients of the Hardman Cup with a specially engraved silver bowl. President Andrews recognized incoming president



Earnest C. Atkins, M.D. presents to J. Frank Walker, M.D. and F. W. Dowda, M.D. of Fulton County Medical Society, the GaMPAC Award for the society contributing the most funds.

John Kirk Train, who read the list of living past recipients of the Hardman Award. Richard Torpin, recipient in 1963; J. W. Chambers, recipient in 1957; and John L. Elliott, who received the award in 1949, were present to accept their silver bowls from Dr. Train.

Distinguished Service Award

Dr. Andrews, stating that the Distinguished Service Award is the highest honor which the Medical Association of Georgia can bestow in recognition of service to the MAG, announced that J. W. Chambers of LaGrange had been selected to receive the 1969 award. Dr. Chambers received a round of applause as he came to the podium to receive this award.

Site of Future Annual Sessions

President Andrews announced that the 1970 Annual Session would be held in Jekyll Island and in 1971 the Annual Session would be held in Atlanta. Dr. Andrews asked that invitations be extended for MAG Annual Sessions in 1972 and 1973, in order to enable the staff to secure the best possible accommodations and begin to make plans for those meetings.

Dr. Andrews recognized Braswell Collins, Councilor from the Bibb County Medical Society, who presented an official invitation from the Bibb County Medical Society to MAG to hold its 1972 Annual Session in Macon. By voice vote, the General Session voted to accept the invitation.

Dr. Andrews then recognized Ronald Galloway, president of the Richmond County Medical Society, who presented an invitation from the Richmond County Medical Society to MAG to hold its 1973 Annual Session in Augusta. The General Session passed on a voice vote a motion to accept this invitation.

Election Results

President Andrews announced the MAG election returns as voted by the First General Session as follows:

President-Elect: F. G. Eldridge, Valdosta

Second Vice President: F. William Dowda, Atlanta

Secretary: John Rhodes Haverty, Atlanta

AMA Delegate: J. W. Chambers, LaGrange

AMA Alternate Delegate: Neal F. Yeomans, Waycross

AMA Delegate: John S. Atwater, Atlanta

AMA Alternate Delegate: Henry S. Jennings, Gainesville

Installation of Officers

President Andrews called for all incoming officers, councilors and delegates for 1969-70 to come to the rostrum for the installation of officers as follows:

President—John Kirk Train, Jr., Savannah (1970)

President-Elect—F. G. Eldridge, Valdosta (1970)

Immediate Past President—Charles R. Andrews, Jr., Canton (1972)

First Vice-President—Ronald F. Galloway, Augusta (1970)

Second Vice-President—F. William Dowda, Atlanta (1970)

Second District Vice-Councilor—Donald R. McKenzie, Thomasville (1970)

Ninth District Councilor—Paul T. Scoggins, Commerce (1972)

Ninth District Vice-Councilor—Robert S. Tether, Gainesville (1972)

Tenth District Councilor—Edwin W. Allen, Jr., Milledgeville (1972)

Tenth District Vice-Councilor—Marion A. Hubert, Athens (1972)

Bibb County Medical Society Councilor—Braswell E. Collins, Macon (1972)

Bibb County Medical Society Vice-Councilor—Marion I. Johnson, Macon (1972)

Cobb County Medical Society Councilor—W. C. Mitchell, Smyrna (1972)

Cobb County Medical Society Vice-Councilor—Reimer Y. Clark, Marietta (1972)

DeKalb County Medical Society Councilor—Floyd R. Sanders, Decatur (1972)

DeKalb County Medical Society Vice-Councilor—M. Freeman Simmons, Decatur (1972)

Fulton County Medical Society Councilor—Fleming L. Jolley, Atlanta (1972)

Fulton County Medical Society Vice-Councilor—Thomas J. Anderson, Atlanta (1972)

Richmond County Medical Society Councilor—Joseph L. Mulherin, Augusta (1972)

Richmond County Medical Society Vice-Councilor—Daniel B. Sullivan, Augusta (1972)

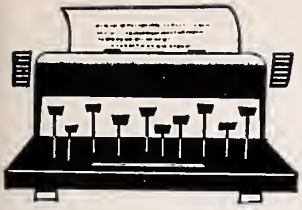
Outgoing President Andrews then turned over the gavel of leadership to incoming President John Kirk Train, who expressed his appreciation to the membership for the honor of being selected president and the trust placed in him.

After recessing the General Session while the House of Delegates held its second session, President Train reconvened the Third General Session.

President Train announced that the official attendance at the 115th Annual Session of the Medical Association of Georgia held in Savannah, Georgia, May 4, 1969, was as follows:

MAG Members—548; Guests—169; Exhibitors—67; Auxiliary—223; thereby making a grand total of 1,007 registered.

There being no further business, President Train adjourned the 115th Annual Session of the Medical Association of Georgia at 2:00 p.m.



F. G. Eldridge of Valdosta Is New MAG President-Elect

FRANKLIN GOODING ELDRIDGE of Valdosta, specialist in roentgenology, was installed as President-Elect of the Medical Association of Georgia at the association's 115th Annual Session in Savannah, May 4-7.

Dr. Eldridge, born in Cook County, Tex., received his B.A. and B.S. degrees from McMurry College, Abilene, in 1929 and 1930. He received his medical degree from Emory University School of Medicine in 1934 and interned at Grady Memorial Hospital, Atlanta.

A Captain in the United States Army Medical Corps during World War II, he served as Chief of the Radiological Service in Camp Blanding, Fla., on the European front, and as Chief of Radiological Service, Fort Bragg General Hospital, N.C. Upon discharge from the Army he entered private practice as a specialist in X-ray diagnosis and treatment in Valdosta.

Dr. Eldridge has served on the Building Committee and as chairman of the Finance Committee of the Medical Association of Georgia for two years. First appointed to Council of MAG in 1957, he served as Chairman for 1967-1968 and 1968-1969. He is also member and past-president of the South Georgia Medical Society and the Eighth District Medical Society, and has been Councilor for the Eighth District as well as Delegate for the South Georgia Medical Society. He is a Diplomate of the American Board of Radiology and a Fellow of the American College of Radiology.

Within the Valdosta community, Dr. Eldridge is member and past-president of the Building Committee of the Board of Education, Valdosta Country Club, and Rotary Club. He is a member of the Elks Club and is on the Board of Trustees of the First Methodist Church.

Married to the former Henrietta R. Jefferies of Gaffney, S.C., Dr. Eldridge has two sons, Franklin Jefferies and John Lowell.

Highlights of the 1969 MAG Annual Session

THE 115TH ANNUAL SESSION of the Medical Association of Georgia was convened in Savannah on May 4-7, 1969. Organized with an almost entirely new format, the Annual Session was expanded from a three- to a four-day meeting. Many innovations were installed including the physician's art show and the

"Medical Mile," an athletic event in which physicians competed for the fastest time over a mile course.

Total registration topped 1,000 and representation from all parts of the state was in evidence.

A full scientific program was offered which included a talk by Dr. Denton A. Cooley of Houston before an audience estimated at 300 people, a symposium on automotive safety and a special program designed for County Medical Society officers.

Reports and resolutions presented to the House of Delegates covered a wide range of subject matter. Among these were reports on additional 1969 MAG dues; policy statement on chiropractic; paramedical school curricula; election of officers by the House of Delegates; osteopathy; MAG staff personnel; conflicts of interest; amendments to the Constitution and Bylaws, and the training of family physicians. A detailed report of each proposal presented to the House, the subsequent recommendation of the reference committee and the final action taken by the House of Delegates appears elsewhere in this issue of the *Journal*.

Additional 1969 Dues

Acting on the report of the Committee on Special Finance, a reference committee of the House recommended that additional dues in the amount of \$75 be levied upon all active members of the association for the year 1969. The House amended this report by increasing the amount to \$100 in additional dues to be collected by September 15, 1969.

Chiropractic

The House voted to approve the following statement as the official policy position regarding chiropractic:

Statement of Policy

It is the position of the medical profession that chiropractic is an unscientific cult whose practitioners lack the necessary training and background to diagnose and treat human disease. Chiropractic constitutes a hazard to rational health care in the United States because of the substandard and unscientific education of its practitioners and their rigid adherence to an irrational, unscientific approach to disease causation.

In 1965, a United States district court, in upholding a state's constitutional right to refuse to license chiropractors, said that "since chiropractic claims to be a complete and independent healing art capable of curing almost all kinds of disease, the state legislature may have felt that the requirement of a foundation in *materia medica* and surgery . . . would be a protection to the public." Without dissent, the United States Supreme Court affirmed the decision.

The wisdom of these decisions by the nation's highest courts justifies the medical profession's educational program of alerting the nation to the public health threat posed by the cult of chiropractic.

Patients should entrust their health care only to those who have a broad scientific knowledge of diseases and ailments of all kinds, and who are capable of diagnosing and treating them with all the resources of modern medicine. The delay of proper medical care caused by chiropractors and their opposition to the many scientific advances in modern medicine, such as life-saving vaccines, often ends with tragic results.

Paramedical Schools

The House voted to direct the Executive Committee to appoint a committee to

study the establishment of minimum requirements for accreditation of the curricula of schools turning out paramedical personnel.

Election of Officers by House of Delegates

In approving the report of the Chairman of Council the House gave its endorsement to the principle of electing the officers of the association (with the exception of councilors and vice-councilors) by the House of Delegates. The House of Delegates will elect officers for the first time at the 1970 session.

Osteopathy

The House gave its approval to several amendments (in principle) to H.B. 655, a bill now pending in the State Senate to create a composite board of examiners in medicine and osteopathy and provide for a mechanism by which osteopaths may achieve full practice privileges on par with medicine.

1. Among the several amendments adopted was elimination of all references to the AMA and AOA in determining the "good standing" of medical and osteopathic schools;

2. Requiring adequate inspection by the Board of Medical Examiners of each medical and osteopathic school not previously approved to be in good standing and requiring that these schools meet the same standards of those already approved;

3. Requiring the same type of inspection or evaluation of internship programs not previously approved;

4. Providing that licensing by reciprocity may be granted only to graduates of schools who take their degree after the date on which the "good standing" of such school has been determined by the Board of Medical Examiners; and

5. Requiring examination or evaluation by the State Board of Medical Examiners upon completion of refresher courses to be given by the two Georgia medical schools as a condition of full practice privileges for those presently holding an osteopathic license.

MAG Staff Personnel

In response to several reports, each recommending the employment of additional staff personnel, the House directed the Executive Committee to make a thorough study of this matter.

Conflict of Interest

The House approved a report forbidding an individual to hold a policy-making position in MAG as defined by the Constitution and Bylaws while simultaneously holding a position with government, health insurance companies and other third party agencies which would create a conflict of interest. The Executive Committee and Council shall determine when a conflict of interest exists.

Constitution and Bylaws

The House approved numerous changes to the Constitution and Bylaws, including one constitutional amendment effective immediately and two others which must lay on the table a year to be voted on in 1970. The former changes the Constitution to conform with the Bylaws and authorizes that a past president shall serve on Council for two additional years following his term as immediate past president.

Of the remaining two, one would change the number of delegates necessary to call a special meeting of the House or the association from 20 delegates to one-third of the membership of the House. The second amendment laying on the table provides for the election of councilors and vice-councilors by their respective constituent societies.

The House also voted to provide for two additional classes of membership to be known as Life Members and Student Members. It also approved a recommendation of the reference committee that interns and residents become eligible for Associate Membership in MAG.

Training of Family Physicians

The House of Delegates gave its support to the concept of establishing a program at the Medical College of Georgia for the training of family physicians. In approving the resolution it authorized distribution of copies to the Board of Regents, the General Assembly and the Governor. It also encouraged Emory Medical School to consider the same type program.

Other Important House Actions

The House went on record in opposition to mass resignations from hospitals by members of the health team; approved a resolution commending GaMPAC; directed the Constitution and Bylaws Committee to investigate the possibility of providing ex-officio membership on the Council for the presidents of the two Georgia SAMA chapters; commended the "Doctor-of-the-Day" program at the State capitol; adopted a report calling for more MAG emphasis on public relations; approved a resolution for transmittal to the AMA House of Delegates calling for qualified physician control and supervision of all diagnostic and therapeutic services such as inhalation therapists, EKG technicians, intensive care nurses, etc.

Awards Presented

Ruben S. O'Neal, M.D., LaGrange was presented the certificate as "General Practitioner of the Year"; J. W. Chambers, M.D., LaGrange was presented with the "Distinguished Service Award"; Carl C. Aven, M.D., Marietta, was the recipient of the first MAG "Civic Endeavor Award"; James L. Becton, M.D., Augusta, took first place in the Scientific Exhibit Awards for his exhibit "Carpal Tunnel Syndrome—Diagnosis and Management." Three GaMPAC awards were presented—two for membership which went to Upson County and the Fourth District, and a third was presented to Fulton County for the largest financial contribution to the PAC movement.

Officers

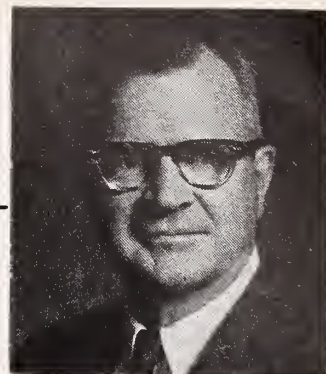
The following new officers were elected and/or installed for the 1969-70 year at the 1969 Annual Session: John Kirk Train, Savannah, president; F. G. Eldridge, Valdosta, president-elect; Ronald F. Galloway, Augusta, first vice-president; F. William Dowda, Atlanta, second vice-president; John Rhodes Haverty, Atlanta, Secretary.

ORTHOPTICS COURSE OFFERED AT EMORY

The Department of Ophthalmology, Emory University School of Medicine, Atlanta, offers a 15-month course in Orthoptics. The program provides highly specialized training which prepares the student to assist the ophthalmologist in the management of cases of amblyopia, strabismus and other problems re-

lated to ocular muscle imbalance. The course is fully accredited by the American Orthoptic Council.

Applications are now being accepted for the 1969-70 session which commences in July 1969. Registered nurses or college graduates may apply. Address inquiries to Mrs. Betty Anne Haldi, Chief Orthoptist, Emory University Clinic, Atlanta, Georgia 30322.



GONE FISHIN' . . .

“FISH . . . NOUN . . . BROADLY, almost any exclusively aquatic animal . . . verb . . . to attempt to catch fish as by angling or drawing a net.”

So does my trusty Webster's "New Collegiate Dictionary" define "fish" and "to fish." Fish and the art of fishing are of universal interest; young and old, male and female, all show interest in our piscatorial friends and how best to lure them from their aquatic haunts onto the dining table. The fish in my office (a mounted largemouth bass on the north wall, a sailfish on the east wall, and my bowl of invisible goldfish) cause more comment from young and old alike than do the quality of medical care they may get, my toy train or even my picture of Marilyn Monroe. And no one enjoys life more than the fisherman when he is engaged in his favorite pastime, whether he be the heavy-tackle, deep-sea-angler, or the cane-pole-and-live-worm type of devotee.

But there is another meaning to the expression "to go fishing," this expression being one the politicians use when they want not to declare themselves on election day; one used by those who want to escape duty or to be somewhere else, or not attend the state medical association annual session. Too many of the members of the Medical Association of Georgia use the days of the Annual Session to "go fishing" and to stay away from the Annual Session, depriving their fellow physicians of the pleasure of their company and holding back from the good of the order the benefit of their counsel in reference committee discussion and debate. Such people are cheating themselves as well as the Medical Association.

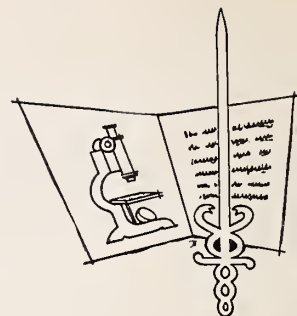
In past years, in order to tempt more people to the session there have been steps taken to streamline the proceedings, on the assumption that the attendance at a short meeting would be greater.

This year the approach was different and due to the aggressive approach of Dr. Preston Ellington and his committees, a jam-up program and a longer session attracted a bigger crowd. The session was the best in years, if not ever. Too much credit cannot be given the various committees and workers for the success of the meeting.

Those who attended were presented excellent scientific programs, great indoor entertainment, outdoor recreation and exercise, for those who wanted it. To those who came, thanks for coming and helping to make the 115th Annual Session a success; for those who did not attend, the MAG is having sympathy chits printed; these will be mailed with your next *JMAG*. Better luck next year.

A cursive handwritten signature that reads "John Kirk Train".

John Kirk Train, M.D.
President, Medical Association of Georgia



DEFEATISM IN LUNG CANCER

JOHN I. DICKINSON, M.D.* *Rome*

RECENTLY RELEASED STATISTICS of the United States Agriculture Department indicate a reversal of the trend toward cigarette smoking. Not only is there an overall decrease in cigarette consumption in the United States, but there is a definite decrease in per capita consumption. This is wonderful news, but unfortunately it does not sound the death knell of lung cancer and all the other by products of the tobacco industry.

From ecologic as well as cytologic studies it seems quite clear that tobacco does its damage over long periods of time and for lung cancer this is 20 to 30 years. We are now harvesting the crops sowed in the '30's and '40's when cigarette smoking became the "in thing." If everyone stopped smoking today we would still face the peak of lung cancer sometime in the next few years. I am often asked by patients if the changes which lead to lung cancer are reversible. My answer is the one given by the American Cancer Society that these changes take at least 10 years to revert.

What does all this boil down to? It means that we in the medical profession must continue our dual approach to lung cancer, namely: education of the young to avoid the habit or quit, and education of the already afflicted to seek early and adequate treatment.

Feeling of Futility

Day in and day out I hear from medical and non-medical sources discussing lung lesions suspected or proven to be cancer, "What's the use, we don't cure lung cancer anyway." After a particularly bad day on the obituary page I sometimes feel like agreeing with them. We all know of cases that have been cured among movie stars and other famous people, but when we try to name some of our own patients, we find they are few and far between. We do have a few cures and they make all the effort at accurate diagnosis and seemingly futile treatment worthwhile. I have two cases that keep me going and I would like to share them with you.

(1) O.M.: This 45-year-old Negro male underwent right middle and lower lobectomy on January 6, 1966, for squamous cell carcinoma. Although the bronchial cuff was clear of tumor by 3 cm., there were positive nodes removed in

* Regional Medical Chairman, American Cancer Society, Georgia Division, Inc.

the specimen. Three months postoperatively he developed a mass in the right thigh which grew rapidly and needle biopsy proved to be squamous cell carcinoma, compatible with metastatic disease. Study failed to reveal other metastases and he was given 4350 r radioactive cesium. Though not considered cured, he is working regularly as a construction laborer and has no evidence of active disease at this time.

Benefit From Radiation

(2) B.B.: This 55-year-old white female underwent right exploratory thoracotomy on January 9, 1965 which revealed a hilar mass infiltrating the pericardium along the pulmonary artery and inferior pulmonary vein. A node was biopsied and contained adenocarcinoma. This was not considered resectable. Though benefit from radiation was doubtful, she was given 4000 r radioactive cesium. Her last chest x-ray was in December, 1968 and is unchanged for the past three years. She has shown no signs of metastatic disease. Needless to say her slides have been reviewed repeatedly.

These are two cases where we were tempted to withhold radiation because of questionable value and inconvenience. Though we can not say we have cures we certainly seem to have bought a great deal of time. I am convinced that an aggressive approach to lung cancer will benefit more and more people as we accumulate knowledge about this dreaded disease.

14 Hospital Circle

IS MEDICAL PRACTICE PRE-MODEL-T?

Someone recently called our present health care system a "pre-model-T economic organization" which does not run and "deserves to be replaced." That someone is United Auto Workers Union president, Walter P. Reuther, who now heads the Committee for National Health Insurance.

This Committee has just opened a Washington office to press for the enactment by Congress of a National

Health Insurance program. Vice-chairmen of the new group are Michael DeBakey, M.D., Baylor University, Dallas; Mrs. Mary Lasker, New York City, and Whitney M. Young, Jr., Executive Director of the National Urban League. Mr. Reuther has announced that the purpose of the organization will be to design a health program and draft proposed legislation to implement the program.

SANDOZ ANNOUNCES NEW FILM FOR PROFESSIONAL AUDIENCES

"The Scream Inside . . . Emergence Through Group Therapy," is a new Sandoz psychotherapy film just made available for qualified professional audiences.

The film presents a wide range of psychotherapeutic group processes and dynamics on many levels, with actual therapy sessions photographed or videotaped. Patient conversation is free of restrictions on subject

matter or vocabulary. The purpose of this film is to communicate concepts basic to an understanding of therapeutic group functions and objectives.

The film may be obtained for showing by addressing a request to Medical Film Department, Sandoz Pharmaceuticals, Route 10, Hanover, N.J.

THE ASSOCIATION



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Fincher, Ronald E., M.D. DE-2—Fulton—Obg.	35 Linden Avenue, N.E. Atlanta, Georgia 30308	Mansfield, Donald L., M.D. DE-2—Fulton—Obg.	300 Boulevard, N.E. Atlanta, Georgia 30312
Fulcher, J. Hershel, Jr., M.D. Active—Ga. Medical— Path.	206 S. 36th Street Savannah, Georgia 31401	Merida, Manuel M., M.D. Active—Baldwin—Oalr.	Central State Hospital Milledgeville, Georgia 31061
Garrett, Robert C., M.D. Active—Flint—GP	412 Church Street Vienna, Georgia 31092	Miller, Georgia D., M.D. Active—Fulton—D	6075 Roswell Rd., N.E. Atlanta, Georgia 30328
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Lazcano, Jorge G., M.D. Active—Baldwin—P	State Hospital Milledgeville, Georgia 31061	Weisman, Evan B., M.D. DE-2—Fulton—I	1002 Lindridge Dr., N.E. Atlanta, Georgia 30324
Legner, Stanley, M.D. Active—Walker—Catoosa- Dade	1 Thomas Rd. Ft. Oglethorpe, Georgia 30741	Whaley, William H., M.D. DE-2—Fulton	Naval Air Station Marietta, Georgia 30060
		Wilbur, Oscar M., Jr., M.D. Active—Ga. Medical— Path.	P.O. Box 6688 Savannah, Georgia 31405

SOCIETIES

The Woman's Auxiliary to the **Baldwin County Medical Society** and Mayor Walter B. Williams, Jr. proclaimed Sunday, March 30, as Doctors' Day in Milledgeville.

Ed Boyle, M.D., was guest speaker at the April meeting of the **Bibb County Medical Society**. He presented a program on coronary atherosclerosis.

R. Paul Crank, Jr., M.D., spoke on the "Importance of Tri-glycerides and Cholesterol in the evaluation of patients who have atherosclerosis and in those individuals who may be at high risk for the disease" at the April 23 meeting of the **DeKalb County Medical Society**.

Albany doctors received a report of their charity activities at the regular March meeting of the **Dougherty County Medical Society**. A free cancer clinic for women and extensive use of free clinics in the Phoebe Putney Memorial Hospital were among the activities reported.

The **Georgia Medical Society** adopted resolutions in its April 8 meeting for eventual construction of a medical school and for retention of the U.S. Public Health Service Hospital in Savannah.

The **Georgia Regional Medical Program** received a \$907,251 U.S. Public Health Service grant from the Federal government April 10.

Gov. Lester Maddox spoke at the April 17 meeting of the **Ninth District Medical Society**, telling the doctors that Georgia is a sick patient that can not be cured with a simple prescription.

PERSONALS

First District

William E. Gray, Jr., formerly of Swainsboro, has been reelected to active membership in the American Academy of General Practice, signifying completion of 150 hours of accredited postgraduate medical study in the past three years. He is presently practicing in Hanford.

Third District

T. Schley Gatewood spoke at the April 4 meeting of the Americus Kiwanis Club, listing items needed to improve that city's image. He said that one of the greatest needs is for 12 more doctors and specialists in medicine, as well as a civic auditorium, a new public library, a 60-bed addition to the city-county hospital and a better public school education system.

Joseph C. Serrato of Columbus was sworn into office as a member of the Georgia Medical Education Board by Gov. Lester Maddox on April 17. He is the first Muscogee County resident to serve on the panel.

Fifth District

Robert W. Candler, Atlanta surgeon since 1940, has been elected to the board of directors of the National Bank of Georgia.

Thomas Mixon Ezzard, retired Roswell physician who practiced medicine in the "horse and buggy" era, was recently honored by the Masons of Georgia and Roswell Lodge 165 with the Grand Lodge Award for 50 years "service to the craft."

Vernelle Fox spoke on "The Employed Alcoholic" at a seminar sponsored by the Department of Psychiatry

and Neurology of the Loyola University Stritch School of Medicine in Chicago.

Lester A. Brown spoke on "Testing Hearing Through the Teeth" at the annual meeting of American Otological Society in New Orleans in March.

Carlos L. Celaya has been certified by the American Board of Urology.

James T. King has been elected to a three-year term on the Council of the American Triological Society ENT.

Thomas L. Tidmore, Jr. has ben elected for a second term as president of the Atlanta Association for Retarded Children, Inc.

Thorne S. Winter, III has been elected a Fellow in the American College of Physicians and an Associate Fellow in the American College of Cardiology.

Bruce Logue presented the Frank Wilson-Gordon Myers lecture, "Coronary Heart Disease—1969," to the Michigan Heart Association in Detroit in April.

Sixth District

Macon physician **Waddell Barnes** spoke to the Bibb County Tuberculosis Association April 21, citing a shortage of medical personnel in Macon and the nation as a condition to force revision of medical practice.

Thomas L. Ross, Jr., Macon cardiologist, is the new director of the east central area of Georgia for the Georgia Regional Medical Program. He is a founder of the Georgia Heart Association.

Henry H. Tift of Macon is the new president of the Middle Georgia Hospital, Inc. He has practiced internal medicine since 1947.

Seventh District

Benjamin S. Anderson, Jr. of Cedartown has been named chief of staff at Polk General Hospital.

Willard Carson and **Thomas Carey** of Chatsworth are returning to medical schools for additional training. Dr. Carson will assume residency in surgery at Georgia Baptist Hospital, Atlanta, in June. Dr. Carey will work in pediatrics in Jackson, Miss., in July.

The Board of Directors of Trion Community Foundation, Inc., presented a resolution of appreciation and regret to **Gwynne H. Little** upon his retirement after 23 years of service to Trion Community Hospital.

Eighth District

Jessie L. Parrott of Hahira was featured as "Businessman of the Week" in the *Hahira Gold Leaf*, March 27.

Edward B. Brown of Waycross was installed as a Fellow of the American College of Obstetricians and Gynecologists at its annual meeting April 28-May 1 in Bal Harbour, Fla.

The Coffee General Hospital Medical Staff gave a luncheon March 31 for the active members and their wives. Those attending were as follows: **Drs. and Mrs. E. D. Bell, R. L. Benson, Dan A. Jardine, K. W. Herndon, C. S. Meeks, T. L. Parker, T. K. Stapleton, and William R. Wills.**

Ninth District

J. Wade Knowlton of Toccoa has been certified by the American Board of Surgery as a specialist in general surgery.

Tenth District

George F. McInnes of Augusta spoke at the April 3 meeting of the Washington Women's Club. He is on the board of directors of the American Leprosy Missions.

Louis Scharff, chief physician at Gracewood State School and Hospital, spoke to the Waynesboro Rotary Club in April on what Georgia is doing in the areas of mental retardation.

Hartwell physician Terrell B. Tanner moved his medical practice to Gatlinburg, Tenn. in May.

DEATHS

Hyland Fairbanks Bent

Hyland Fairbanks Bent, Midville physician, died April 22 in an Augusta hospital after an extended illness. He was 93 years old.

A native of Brunswick, Nova Scotia, Canada, he served as mayor of Midville for 14 years and practiced medicine there 55 years. He was graduated in 1906 from the University of Georgia School of Medicine and studied at Boston and New York City Poly Clinic.

He was a member of the American Medical Association, Phi Rho Sigma fraternity, and School Board of Midville. He was also a member of the Midville Masonic Club, Lions Club, Shriner of Alee Temple of Savannah and the Burke County Medical Society.

He is survived by his nieces, Mrs. A. Willard Carlson of Falls Church, Va., and Mrs. William A. Pye of Leomister, Mass.

Joseph Edwin Griffith

Joseph Edwin Griffith, 59, chief physician for Lockheed-Georgia Co., died April 3 in a private hospital.

A native of Buchanan, Ga., he received his medical degree from the Medical College of Georgia at Augusta. He did graduate work in obstetrics and gynecology at Tulane University Medical School in New Orleans and studied at the School of Aviation Medicine at Randolph Field, Tex.

During World War II he was a medical officer and flight surgeon in the Air Force. He went into private practice in Rockmart after the war.

Dr. Griffith was a member of the American Medical Association, the Aero-Medical Association, the Air Line Medical Directors Association, the Fulton County Medical Society, Industrial Medical Association, and the Medical Association of Georgia. He was also a member of the Radiation Control Council of Georgia, and was on the staff of Kennestone Hospital in Marietta.

He is survived by his wife, a daughter, a brother and two sisters.

John Hayes Sherman, Sr.

John Hayes Sherman, Sr. died April 19 in Augusta.

A graduate of the Medical College of Georgia, he was a professor of surgery and chief of the Department of Surgery at the college. He was a veteran of World Wars I and II.

Dr. Sherman was a member of the Richmond County Medical Society, Medical Association of Georgia, and the American Board of Surgeons. He was also a member of the Alpha Omega Alpha Society.

He is survived by a daughter, Mrs. John D. Capers of Augusta.

THE MONTH IN WASHINGTON

Health, Education and Welfare plans to impose Blue Shield schedules for physicians under Medicaid and to limit payments to hospitals under Medicaid and Medicare drew strong responses from the American Medical Association and the American Hospital Association.

Dr. Dwight L. Wilbur, president of the AMA, urged in a letter to Robert H. Finch, HEW Secretary, that all segments of the health care field be consulted in effecting economies in government-paid health services.

Offers Composite Experience

"The American Medical Association is eager to make available to your office the composite experience and judgment of the nation's physicians, who are the

principal providers of health care to all the people," Dr. Wilbur said. "The needs and problems of patients in all walks of life, at all income levels, come to their attention, in composite, more than a billion times a year.

"It has always been a principle of both the humanity and the professional code of the physician that no one shall ever be denied quality health care because of his inability to pay. The present concern is how this universal care can best be provided within a viable economic system and in the face of burgeoning demand for medical manpower, services, and facilities. . . .

"The knowledge and judgment of the nation's physicians, as well as of the prepayment plans, health insurance industry, hospitals, the allied health profes-

sions, the actuaries and others, must be enlisted in your battle against the health-care portion of the inflation problem."

HEW Announcement

Dr. Wilbur wrote Finch following the HEW announcement that federal spending on the Medicaid-Medicare programs would be trimmed by \$328 million through imposing Medicaid fee schedules based on prevailing Blue Shield rates, limiting mental illness benefits under Medicaid and cutting down hospital overhead allowances in Medicaid and Medicare.

"It is important to recognize that there are many variables in the circumstances of payment for medical and hospital services," Dr. Wilbur said. "Local needs and resources, the educational and motivational levels of the people, the economic conditions of the state and the community are among the reasons for the differences exhibited by the payment patterns of the Blue Shield plans and health-insurance companies.

"These circumstances must be the foundation for any policies involving cost and payments. No universal pattern, no matter how many variations it may try to provide, can be imposed on the thousands of localities without wreaking havoc and probably increasing inefficiency and costs."

Warning to Doctors

Concerning the imposition of Blue Shield rates as fee schedules under Medicaid, Dr. Wilbur warned in an address before the American Society of International Medicine in Chicago that a later step "might be that of physicians in groups on salary and abandonment of the fee-for-service principle." He said that physicians, in combatting such government efforts, must accept the major responsibility of keeping fees as moderate as possible.

The American Hospital Association protested in a letter to President Nixon against removal of the two per cent overhead allowance for hospitals. Officially representing the AHA, Ray R. Eppert, Detroit, Mich., hospital trustee, said in a memorandum accompanying the letter to Nixon:

Serious Threat

"The recent announcement of a reduction in Medicare reimbursement poses a serious threat to institutional integrity and, therefore, to the ability of hospitals to serve the sick and injured of this nation. Hospitals have been repeatedly assured at the highest levels of government that Medicare changes would not be made without consultation with their designated representative, the American Hospital Association.

"The AHA has tried repeatedly but unsuccessfully to meet with Secretary Finch. It is incredible that the Federal government would propose, without any consultation, removal of the two per cent allowance which is a proper component of reasonable costs guaranteed under the law as passed by the Congress.

"The department apparently deemed it unnecessary to consult with the hospital field, and, as far as can be determined, made no serious study of the effect of the proposed reduction on hospitals. Payment of nothing but raw costs will lead . . . to the serious underfinancing of our hospitals."

Investigation Target

Drug combinations became the target of the Senate Small Business Subcommittee's investigation of the prescription drug industry.

Medical school professors critical of drug combinations were called as witnesses in two days of hearings opening this phase of the drug industry probe which began nearly two years ago. It was not indicated when, or even whether, drug company representatives would have an opportunity to defend their combination products before the subcommittee.

Dr. Heinz F. Eichenwald, a National Academy of Science drug specialist, told the subcommittee that "misleading advertising" had lured "the gullible physician" into prescribing useless and sometimes dangerous drug combinations. He also said continued use of drug combinations "amounts to a strong indictment of the ability of many physicians to judge what is effective and what isn't."

Testify on Drugs

Dr. Eichenwald, pediatrics chairman at the University of Texas Southwestern medical school in Dallas, and Dr. William M. Kirby, a medical professor at the University of Washington medical school in Seattle, testified on the opening day of hearings on combination drugs conducted by the subcommittee which is headed by Sen. Gaylord Nelson (D., Wis.).

The two physicians were among 30 drug experts who evaluated combination drugs for the National Academy of Science. The experts' unanimous report said the combinations were useless and sometimes dangerous.

The report caused the U.S. Food and Drug Administration to serve notice April 2 that the 78 combination drugs studied by the scientists would be banned from the market unless drug makers could prove the Academy studies were wrong. Drug companies are fighting the FDA order as to many of the combinations that would be banned.

Dangerous Prescriptions

Eichenwald and Kirby both testified doctors are widely prescribing the combinations despite numerous warnings of their potential danger. Eichenwald said drug firms point to the admittedly widespread use of combinations to state that physicians must therefore have demanded them. "The opposite is true," Eichenwald's prepared testimony said. "The demand was created by misleading advertising."

Restriction Urged

In another action, Nelson (D-Wis.) urged the FDA to restrict cyclamate-sweetened products to a prescription-only basis. In a letter to FDA, Nelson said "tens of millions of children and adults across the nation are unwittingly being exposed to potentially serious health hazards by the unnecessary consumption of cyclamate-sweetened soft drinks, cereals, desserts and 'sugar-coated' pills."

Harmful Effects

He added "increasing scientific evidence indicates that cyclamates can cause chromosome breakdown, the birth of undersized offspring in animals, inter-

WASHINGTON / Continued

ference with effectiveness of certain antibiotics, persistent diarrhea, liver diseases, skin irritation and eruption, difficulty with blood clotting and high blood pressure."

Cyclamate was originally developed as a sugar substitute for diabetics and others forced to restrict their intake of sweets. The FDA recently proposed regulations on labelling and ingredient content for cyclamate, often used now as a general substitute for sugar.

Health Program

The Joint Commission on Mental Health of Children is recommending a broad program aimed at bettering the health of the nation's children and youths at an estimated cost of \$6 billion to \$10 billion a year.

The Commission recently disclosed its recommendations at the annual meeting of the American Psychiatric Association in advance of its report to Congress. The 54-member commission, which has completed a three-year, \$1.5 million study, was established by Congress in 1965.

Legislation Promised

Sen. Abraham A. Ribicoff (D., Conn.), who introduced the legislation to set up the committee, said he would promptly introduce legislation to carry out the commission's recommendations.

The recommendations included national health insurance for persons up to 21 or 25 years old; family planning and birth control; prenatal care; pediatric care for children up to age three, and physical and mental health services for older children.

Other Recommendations

—Federal funding for about 100 child development councils to help guide families through the confusion of government agencies in order to insure diagnostic treatment and preventive services for children.

—Appointment of a presidential council of advisers on children and youth, similar in position and prestige to the Council of Economic Advisers.

—Establishment of State commissions and local authorities on child care.

Government Financing

—Federal financing of about 10 evaluation centers to consider the working of the child development councils.

—Publicly supported day care available for all children.

—Federal funds for training child health and welfare personnel.

—Tax incentives to induce people to service in slum areas.

Dr. Reginald S. Louri, Washington, D.C., psychiatrist, is chairman of the joint commission.

Nixon, in a Feb. 19 message to Congress, said: "So crucial is the matter of early growth that we must



for psychiatric treatment

Peachtree Hospital, located in Atlanta, Georgia, is a complete psychiatric, alcoholic and drug addiction treatment facility accredited by the Joint Commission on Accreditation of Hospitals. The hospital has 65 beds, 47 of which are devoted to the care of psychiatric patients

and 18 of which, in a separate area, are for patients with acute cases of chronic alcoholism or drug addiction. Treatment procedures include psychotherapy, electroconvulsive shock therapy, subinsulin coma and chemotherapy. We will be pleased to provide further information upon request.

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make a national commitment to provide all American children an opportunity for healthful and stimulating development covering the first five years of life."

Student Drug Experimentation

The chairman of the AMA Committee on Alcoholism and Drug Dependence estimated that 5 per cent of U.S. college students have tried LSD and 20 per cent of high school and college-age youths have experimented with marijuana and other hallucinogenic drugs.

The chairman, Dr. Henry Brill of West Brentwood, Long Island, N.Y., made the estimate in testimony before the Senate Health Subcommittee.

Spreading Abuse

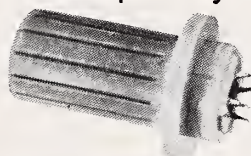
"And," he added, "although no accurate count has been made, there are signs that the abuse of heroin and other so-called 'hard' narcotics is spreading into the suburbs."

Dr. Brill told the subcommittee that the nation's physicians increasingly "are being called upon to treat patients with drug problems, and to give counsel to anxious and bewildered parents who are discovering that 'it can happen' to their sons and daughters."

He emphasized the need for more research in the narcotics field.

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of political action, or we shall be
mastered by those who do."*

—Raymond Moley

JOIN GAMPAC

Tobacco-Poisoning and Its Effects Upon the Eye-sight

BY A. W. CALHOUN, M.D., ATLANTA

Professor of Eye, Ear and Throat Diseases, in the Atlanta Medical College

That so palpable a fact as "tobacco blindness" should have so long remained unknown to the world, is indeed astonishing. Many physicians, and the people at large, are still skeptical, but among oculists, it has long been known that the excessive, and in many instances the very moderate, use of tobacco will produce a train of symptoms, which, if let alone and the same cause be continued, will ultimately end in a partial or complete loss of sight, known as "tobacco amaurosis." That it does more or less damage in almost every instance, can be readily demonstrated by examining the throat of any smoker, in whom you will find unmistakable evidence of slight or severe pharyngitis. It is not necessary to go far out of your way to find more than one person who justly attribute their unsteady gait, their tremulous hand and general "nervousness" directly to the habit of chewing or smoking, or both. I doubt not but that each one of you here can call to mind some friend or acquaintance, whose mental as well as physical strength has been seriously undermined, if not wrecked, by tobacco-poisoning. While damage may be expected from tobacco if used in any manner, it is mainly through smoking that the system is so filled with the poison that the optic nerve undergoes partial or complete atrophy, with corresponding blindness. There is, perhaps, nothing surprising in the fact that a large majority of one's acquaintances smoke, but there is something amazingly fearful in the quantity of tobacco used each day by an old smoker. The active principle, nicotine, is very abundant in tobacco, and is readily developed by burning. The smoker takes this poisonous principle into the mouth, the system becomes saturated, the delicate and sensitive nerves of vision become diseased, and their death, or atrophy, is the termination. That men may, in many instances, harmlessly use tobacco for a long series of years, is no more an argument in opposition to its evil effects than that alcoholic stimulants can be taken, in exceptional cases, for a long life time without serious detriment to the individual. That it injures the nervous system will scarcely be doubted by any one acquainted with its physiological effects, and that it takes the life of the nerve of sight, is now a fact beyond question.

The history of the following few cases, taken from

the records of a large number in my possession, will give a fair insight into the nature of the disease under consideration.

Case 1. Mr. B, aged 50, is a large, vigorous man, in every way apparently in good general health, but for more than eighteen months has been gradually losing his sight. He is a farmer, and in the open air almost the entire day, and has been smoking for twenty years, but not till one and a half years ago did he notice any unpleasant effect from it. The quantity of tobacco daily consumed is difficult to estimate, but he is smoking his pipe from rising in the morning till he retires at night, with the exception of the time devoted to his meals. The quality is what he calls "first-class plug" tobacco, cut and rubbed into very small pieces, before being put into the pipe. The vision began failing, by his seeming to look through a thin cloud, which dimness has gradually increased, till finally, all objects appear covered by dense smoke. Accurately estimated, his vision fell to 10%, and it was only with very strongly magnifying glasses that he could, even for a few moments, read very large newspaper type. There had never been the slightest pain, merely a gradual diminution of sight. At night he found the vision grew invariably more indistinct. The little floating bodies in the vitreous ("mouches volantes") were a great source of annoyance to him. With the aid of the ophthalmoscope, I found both optic discs decidedly anaemic, the right showing the white atrophic appearance much more than the left. The retina on each side was also more or less anaemic.

The treatment of this man was the immediate and complete cessation of the use of tobacco, and the administration of $\frac{1}{20}$ gr. sulphate of strychnia three times daily.

It is now two years since the beginning of the treatment and his vision has been raised from 10% to $\frac{10}{12}$ (almost normal) and, with proper glasses, he reads ordinary print with ease and comfort.

Case 2. Mr. W., aged forty-two years, a banker, has smoked fifteen to twenty cigars a day for the last several years, but remains in perfect general health. For the past six months he has continually seen floating bodies (mouches volantes) before him, and sees everything through a mist. Towards night this mist increases in thickness, and very much obscures all objects. He has had no pain, but seeks advice be

cause of increasing loss of sight. The ophthalmoscope shows an almost perfectly white papilla (atrophy of the optic nerve) in the left eye, and an anaemic condition of the nerve and retina in the right eye.

At once he stopped the use of tobacco, and took sulphate of strychnia three times daily, and so regulated his business that he could remain a good portion of the day in the open air. The left eye remains about in the condition as in the beginning of treatment, but the right has been fully restored to its normal condition, and he is now constantly and actively engaged in his business.

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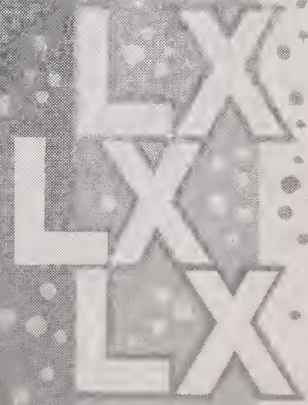


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Design by Mr. Ike Hussey of Higgins-McArthur/Longino & Porter. Last month's design was by Marie Seaman, also of Higgins-McArthur/Longino & Porter.

*Arthritis, Deafness, and Saddle Nose
(Relapsing Polychondritis)*

Special Article

Medical Grand Rounds Medical College of Georgia

A. J. BOLLET, M.D.,* J. G. SMITH, M.D.,† G. R. MUSHET, M.D.,‡ and
F. AUSTIN, M.D.,§ *Augusta*

DR. AUSTIN: THIS WAS THE FIRST Medical College of Georgia admission of a 56-year-old married white male, headmaster of a private school, with a chief complaint of deafness.

Twenty-seven years ago the patient had an appendectomy, followed by "generalized blood poisoning," and was then confined to bed for seven months because of continuous fever. Since that time, he is known to have had a continuous leucocytosis, varying between 12,000 and 25,000, and his Wintrobe sedimentation rate has ranged between 15 and 95 mm. per hour. Following recovery from his extended illness, he was well until 15 years ago when he experienced several episodes of vertigo and shortly thereafter noticed flattening of the bridge of his nose to the extent that he was unable to wear his glasses. During the same year he had an episode of pain and swelling in his hand, knee and ankle joints and was told he had rheumatoid arthritis. He was treated with aspirin for two years, with improvement; he has had no further joint pain except for a brief recurrence eight years ago. Nine years

before admission he had an episode of hemoptysis; bronchoscopy at that time was normal. Three years ago he noticed pain in both eyes, followed a week later by a single episode of diplopia lasting 36 hours. Evaluation for a brain tumor at another hospital disclosed normal findings. Six months ago he began to notice a slow decrease in hearing, then suddenly became totally deaf. He was told that he had a vascular accident in his right ear and was hospitalized and treated with vasodilators and anticoagulants for five days. Evaluation of his hearing loss disclosed enough residual hearing to benefit from a hearing aid. Using the hearing aid, he was able to function during the next three months, but his external auditory canals became progressively swollen, hot, and erythematous. Insertion of the aid was painful. He had to discontinue use of the hearing aid, but was able to hear with an amplified telephone. As headmaster of a private school, the hearing deficit limited his effectiveness at work. During six months of hearing loss he again had arthralgia and further flattening of the bridge of his nose. During the six weeks before an entry into this hospital he was treated with antibiotics without apparent result, and was referred to the Medical

* Professor and Chairman of Medicine.

† Professor and Chairman of Dermatology.

‡ Assistant Professor of Neurology.

§ Resident in Medicine.

GRAND ROUNDS / Bollet et al.

College of Georgia Hospital by a physician member of his family.

As a young boy he had swelling in his right knee which responded to treatment with sunlight. He was a known diabetic for two years, successfully controlled with acetohexamide (Dymelor) and diet. He smoked about a pound of pipe tobacco a month, drank one cocktail a night for about 20 years.

Healthy Appearance

On admission physical examination, the patient was a healthy appearing 56-year-old white male, who was extremely deaf but otherwise in no distress. His blood pressure was 130/90, pulse was 90, temperature was 37°C. (98.6°F). The skin revealed scattered cherry angiomas. He had a large nontender right supraclavicular lymph node. No evidence of episcleritis was noted, and his eye examination, including the fundi, was within normal limits. The nose appeared normal with no tenderness. The left external ear was normal, but the right was erythematous and tender and the skin of the external canal was hyperplastic. The tympanic membranes appeared normal. His neck was normal; the thyroid was not palpable. His chest was clear, there was no cardiomegaly or murmurs. His liver edge was palpable three centimeters below the costal margin but was not tender; his spleen was not palpable. The genitalia and rectum were within normal limits. The joints revealed a full range of motion without swelling or tenderness. All pulses were present bilaterally. The neurological examination was normal except for the gross loss of auditory function.

His hematocrit was 36 per cent; his white count was 12,500 with a normal differential; urinalysis was within normal limits. His chest x-ray showed slight pulmonary fibrosis and questionable osteoporosis. An air bronchogram of his trachea appeared normal. EKG was normal. The Dermatology Service performed a biopsy of the right ear lobe which showed chronic inflammation of the skin. Loss of cartilage matrix was seen on staining with toluidine blue.

We think that this patient has the disease known as Relapsing Polychondritis. Accordingly, he was treated with prednisone, 10 mg. three times a day. After a week the pain, tenderness and induration of the ear decreased and he was able to successfully insert his hearing aid and to hear. Following improvement, prednisone was gradually decreased and he was discharged. Subsequently, his hearing improved further, and he returned to work.

DR. BOLLET: THIS PATIENT APPARENTLY has the syndrome of Relapsing Polychondritis. This disease is being observed and reported at an increasing rate of frequency; there are now 51 cases in the literature, but undoubtedly many more cases have not been reported. As with many diseases, when first described they seem rare, but when we are able to recognize them, the incidence rises rapidly. The true frequency of this disease remains to be seen.

This patient illustrates many of the common manifestations of Relapsing Polychondritis. The fact that it is relapsing is evident from his history. Involvement of many sites of connective tissue, and particularly cartilage, is characteristic; the swelling and the deformity of his ears and nasal cartilage are the two most dramatic, most obvious sites of involvement. The process usually progresses to collapse of the ears and of the cartilaginous portion of the nose. Deformed, cauliflower ears and a saddle nose, as a result of destruction of cartilage, are typical in this case.

Hearing is often impaired because of collapse of the external auditory canal but apparently there is also involvement of the inner ear by the disease. This patient was told that he had nerve deafness and we did not have the opportunity to evaluate this carefully when he was here. Nerve deafness probably would not be part of the disease if truly present, but the improvement in hearing with treatment makes it unlikely. The ossicles of the inner ear are apparently affected in this disease, although no pathologic observations on the inner ear have been reported. The fact that there is a good deal of dense connective tissue in the ear makes it extremely likely that the pathology there was the same as the pathology in other parts of the body and that the deafness, therefore, is an intrinsic part of the disease. Further evidence for the direct involvement of the inner ear in the disease is the reported occurrence of labyrinthine vertigo in about a quarter of the patients; today's patient had mild episodes of dizziness in the dark, but no clear-cut involvement of the labyrinth on gross testing.

Joints Sometimes Affected

The joints are sometimes affected in this disease, and this patient had the type of involvement usually seen. Again, the cartilage is affected with little evidence of the synovitis typical of the common types of inflammatory arthritis. Although sometimes joint deformities can result from cartilage destruction, the arthritis is usually limited to mild and transient arthralgia.

The most critical sites affected are in the respiratory tract. When cartilage of the trachea or bronchi are involved, tracheal collapse with suffocation or bronchial narrowing with secondary infection of the lungs can occur. The mortality rate is rather significant; of 51 patients reported, 11 have died thus far, with an average duration of seven years from the onset of symptoms; the range of duration of the disease in the fatal cases was 10 months to 20 years. Respiratory failure has been the most common cause of fatal outcome.

It is evident that this disease is not limited to the cartilaginous connective tissue, but dense fibrous connective tissue elsewhere is also affected; in the eye, an episcleritis, such as occurred in our patient, is a characteristic manifestation, but not a life-threatening one. Table I, taken from a recent summary of the problem by Carl Pearson, shows the most common clinical manifestations and the frequency of involvement in the patients who have been reported thus far.^{1, 2} Most frequent have been ear and nasal cartilage involvement occurring in almost 90 per cent of the reported cases; fever and arthritis were observed in roughly 80 per cent of the patients; laryngotracheal involvement in 70 per cent; episcleritis or conjunctivitis in 60 per cent, and defective hearing in 50 per cent. Costochondral cartilage involvement also occurs; one wonders what the relationship of this disease is to Teitze's syndrome. Recently, involvement of the dense connective tissue of the aortic wall or valve ring has been reported, and valvular insufficiency has appeared in patients with this disease, producing acute fulminating congestive heart failure.^{1, 3} Apparently involvement of the aortic valve is another important cause of mortality in this disease. Surgical correction of

the aortic insufficiency resulting from relapsing polychondritis has been attempted with some success.

Radiologic Observations

Table II summarizes some of the radiologic observations which have been made in this disease. Articular cartilage damage can cause narrowing of the joint spaces; this is mentioned in about 40 per cent of the patients. The ear cartilage not only decreases in volume, causing collapse of the ear, but may calcify. Tracheal narrowing has been visualized by x-ray. Interestingly, osteoporsis has been observed in at least some of the patients, but the exact frequency or mechanism responsible is not clear at the moment.

A fundamental alteration in relapsing polychondritis is a loss of the supporting function of the connective tissue matrix. The decrease in cartilage substance can lead to the collapse of ears or trachea. Distortion of other structures, such as the aortic valve ring, can lead to valvular insufficiency. Infiltration by leucocytes and plasma cells, and fibrous tissue proliferation around the sites of loss of cartilage matrix occurs, but it is not at all clear whether the inflammatory process is the primary change. My opinion is that the change in the cartilage matrix occurs first and the cellular infiltration and fibrosis is the secondary phenomenon, rather than vice-versa. I suggest this because of instances of cartilage breakdown occurring without the cellular reaction. This may be more common than realized, since the cartilage breakdown may not be apparent unless special stains are made. The routine hematoxylin and eosin sections do not suffice to show early alterations in cartilage matrix; toluidine blue or other stains for the matrix poly-

TABLE I
INCIDENCES OF VARIOUS FEATURES IN RELAPSING POLYCHONDritis*

Clinical Manifestation	Present in Our Patient	Occurrence in Reported Cases No. Affected/ No. Reported	Frequency Per Cent
Ear cartilage lesions	yes	46/51	88
Nasal cartilage lesions	yes	41/50	82
Fever	by history	22/27	81
Arthropathy	by history	41/52	79
Laryngotracheal lesions	no	33/48	69
Episcleritis or conjunctivitis	by history	29/49	59
Defective hearing	yes	22/45	49
Costochondral cartilage lesions	no	21/46	46
Iritis	by history	11/42	
Labyrinthine vertigo	by history	uncertain	(?25%)
Aortic valve lesions	no	uncertain	(?8%)

* Modified from Dolan et al.² and Pearson.¹

saccharide will detect the earliest evidence of loss of matrix, as occurred in our patient.

The lesions seen in the aorta include subintimal basophilia, fibrosis in the media, and disruption of elastic fibers.^{1, 3} Finally, frank necrosis can occur in the aorta wall. Some round cell infiltration also occurs, but the pathologic observations on this tissue have been very few and a full description of the lesions cannot be given yet.

TABLE II
RADIOLOGIC ABNORMALITIES IN
RELAPSING POLYCHONDritis*

	Estimate of Frequency Per Cent
Articular cartilage damage	40
Calcification of ears (Pinna)	40
Tracheal narrowing	32
Osteoporosis	32
Cardiomegaly (rough estimate)	20

* Modified from Pearson.¹

Information for Speculation

Although the basic pathogenetic mechanism of the disease is unknown at the moment, there is enough information and knowledge of some analogous phenomena on which to base some speculation. The primary change is apparently in the matrix of the cartilage or other connective tissue sites; thus the ground substance seems to be the primary site of the involvement. A decrease in concentration of the matrix components, in particular the acid polysaccharides or glycosaminoglycans, occurs early; this is associated with inflammation. The earliest clinical manifestations noticed are usually those of inflammation, with pain and swelling of affected sites; pain due to alteration of cartilage matrix alone is not likely since there are no nerve endings in cartilage. Subsequently, the loss of ground substance affects the physical properties and therefore the function of the connective tissue resulting in collapse of cartilage or dilatation of the aortic wall or valve ring.

The mechanism of the loss of ground substance components remains to be established, but the enzymes which can be responsible for turnover of cartilage matrix polysaccharide are known. Both

proteolytic enzyme and hyaluronidase are present either in cartilage or adjacent tissues and may play a role, but proteolytic enzyme seems to be most likely. The matrix of cartilage contains large amounts of protein-polysaccharide complex containing chains of chondroitin sulfate and some keratan sulfate linked to a backbone or core of protein. This complex molecule is responsible for most of the properties of cartilage and degradation of it can lead to collapse of the cartilage. The protein core can be considered an anchor, keeping the polysaccharide in place; digestion of the protein causes the intact polysaccharide chains to diffuse out of the cartilage. For example, when papain is injected into rabbits, their ears fall down. Chondroitin sulfate is lost from the matrix, appearing in the blood and urine. The loss of polysaccharide from the matrix causes it to soften and collapse. In these rabbits, the trachea may collapse also, and articular cartilage shows the same loss of matrix polysaccharide. About 48 hours later, however, if no further papain is injected, the cartilage cells replace the chondroitin sulfate and the ears and other cartilages are restored to normal.

There is one report of increased polysaccharide excretion in the urine of a patient with the relapsing polychondritis, suggesting a phenomenon similar to that which occurs in the papain treated, flop-eared rabbits.

Release of Enzymes

Proteolytic enzymes capable of degrading the protein-polysaccharide of the matrix is present in lysosomes in the cartilage cells. One is tempted to speculate that release of lysosomal enzymes from the cartilage cells causes the increased degradation of the cartilage matrix polysaccharide in this disease, resembling the similar phenomenon which occurs when proteolytic enzymes are introduced into cartilage from without. The problem in these patients is apparently the release of proteolytic enzymes, presumably from the cartilage lysosomes, causing degradation of the protein-polysaccharide and the loss of cartilage substance; there is an associated inflammatory reaction, but the reason for this is not clear. Steroids are clinically beneficial in relapsing polychondritis; they may be beneficial because of suppression of the inflammation, if the inflammation is primary, but they may be effective because steroids can stabilize lysosomal membranes and retard the release of lysosomal enzymes.⁴ Steroids, thus, may actually be altering a basic mechanism of pathogenesis in this disease. The clinical results reported with steroids, as in today's patient, have been very impressive, and they can be life-saving when tracheal collapse threatens.

The presence of lymphocytes and plasma cells at sites of the cartilage breakdown suggests an immune phenomenon is occurring, and it is now the fashion to suggest an auto-immune process in all diseases of unknown etiology. In view of the presence of cells which are members of the immune system in these lesions, an immune response, classifiable as an auto-immune response, is undoubtedly occurring but that statement should not be confused with a description of the etiology of the disease. The question remains why components of the cartilage have become antigenic and what components are antigenic. More fundamental in terms of the key pathologic alteration in the disease is the question whether the presence of active enzymes capable of degrading the cartilage matrix is the result of the immune response, or the cause of the altered antigenicity of the cartilage; a process independent of but occurring concomitantly with the immune phenomena is obviously an additional possibility. All three mechanisms must be considered at the present stage of our knowledge.

Effectiveness of Therapy

It should be added that the effectiveness of steroid therapy does not help us distinguish among the pathogenetic mechanisms described. Since steroids suppress inflammation, suppress the immune response, and stabilize lysosomal membranes, they are obviously agents of choice in the management of this disease, but do not aid in understanding basic mechanisms.

There is another possible therapeutic approach to the basic defect in this disease, namely the use of epsilon-aminocaproic acid, which is marketed under the name of *Amicar*. This amino acid will inhibit the action of certain proteolytic enzymes,

namely those which hydrolyze peptides at the site of lysine residues, since it is an analogue of lysine, lacking the alpha amino group of that amino acid. Plasmin, trypsin, and cathepsins of cartilage matrix protein-polysaccharide are inhibited by it.⁵ This agent may thus be useful in the management of this disease, but to my knowledge has not been tried clinically. We did not want to take the time to try this agent in our patient because the hearing problem was so important that treatment with steroids had to be instituted immediately.

Although there is little in the literature to help us predict the prognosis of the hearing problem in our patient, we have reason to be hopeful. Once the diagnosis was made and steroid therapy instituted, a rather dramatic change in the clinical course has occurred, his hearing improved considerably, and has continued to improve progressively.

These conferences are taped weekly and are selected and edited by Dr. A. Calhoun Witham, Professor of Medicine, Medical College of Georgia. The participants are principally faculty and house staff of the Department of Medicine, or Junior Medical Students assigned to the patients. Members of other departments are so identified.

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Cardioversion

BERNARD LOWN, M.D.,* *Harvard, Mass.*

IT IS NOW SIX YEARS since the introduction of cardioversion as a method for terminating arrhythmias. To date many thousands of patients have been successfully treated. This extensive experience provides an adequate basis for assessing the advantages and limitations of cardioversion. Ectopic tachycardias in the past have been controlled by means of drugs. The use of antiarrhythmic agents, however, presents a number of limitations. To reach an effective dose requires a time-consuming biologic titration involving frequent if not continuous monitoring of patients. However, whatever the precautions, serious side effects frequently occur. Furthermore, all anti-arrhythmic drugs, when given rapidly or in large doses or when administered intravenously, depress myocardial contractility and reduce peripheral resistance. This may prove especially dangerous in the presence of an arrhythmia which already has compromised cardiac reserve.

Method and Rationale

The majority of human tachyarrhythmias are self-sustaining by virtue of recirculation of an excitable stimulus over a fixed or variable pathway. When the pathway is blocked, the ectopic mechanism is extinguished and the sinus node resumes its usual role as dominant pacemaker. Such block can be induced by an electrical pulse which depolarizes the entire heart and thereby abolishes momentarily all excitable activity. The hazard of electrical

shock, namely, cardiac asystole and ventricular fibrillation, can be prevented by the use of brief direct current (DC) pulses and by discharging these pulses into a safe part of the cardiac cycle. The dangerous part of the cycle is the vulnerable period occurring at the time of inscription of the apex of the T wave. Electrical energy triggered into the heart during the vulnerable period results in ventricular fibrillation. Transthoracic DC shocks synchronized to discharge outside the T wave are both effective and safe for terminating a diversity of arrhythmias.

The Technique of Cardioversion

Since the most common disorder treated with cardioversion is chronic atrial fibrillation, the steps to be described apply especially to this arrhythmia. However, the same procedure with but slight modification is applicable to other ectopic mechanisms. In the case of elective reversion, the patient is started one to two days before the procedure on maintenance quinidine therapy in a dose of 0.3 gm. (5 gr.), six hourly. The objective of administering quinidine is four-fold: 1) to develop adequate serum and tissue levels in order to prevent prompt recurrence of the arrhythmia; 2) to determine whether quinidine is well tolerated; 3) to obtain a small dividend of reversions observed in about 10 per cent of patients with chronic atrial fibrillation while on maintenance quinidine therapy; and 4) to diminish the incidence of ectopic mechanisms immediately following cardioversion. One hour before the procedure 0.1 gm. pentobarbital sodium (Nembutal®) is given orally. Transient amnesia is achieved

Prepared by the Georgia Heart Association for this Journal.
* Medical Clinics of the Peter Bent Brigham Hospital, Cardiovascular Laboratories of the Department of Nutrition, Harvard School of Public Health.

by use of diazepam (Valium®) given in a dose of 2.5 mg. intravenously and repeated at two minute intervals until mild anesthesia. This drug is well-tolerated and generally about 10 to 15 mg. suffices for the desired effect. Two electronic paddles are coated with liberal layers of conductive paste and applied in a front-back orientation. The anterior paddle is held with pressure on the midsternum while the patient lies on the posterior paddle which is located in the left infrascapular region.

Perhaps the most important aspect of the procedure is to begin with low energy settings of one to five watt seconds (WS) and then proceed with higher energies such as 25, 50, 100, 200, 300, up to 400 WS. The practice of energy titration protects against serious complicating arrhythmias. For example, if electric shock provokes ectopic beats at low energies before reversion is achieved, one has the option of postponing the procedure or else administering lidocaine in a bolus of 50 mg. intravenously. If such titration is carried out, it is not necessary to discontinue digitalis drugs prior to cardioversion. The reversion itself takes but a fraction of a second and the patient is usually awake within a few minutes. When a normal mechanism is restored blood pressure generally rises. There is no need to monitor the patient for a period longer than one hour if the procedure is uncomplicated.

Selection of Patients

How are patients to be selected for cardioversion? Two questions need to be answered: 1) is the arrhythmia susceptible to electrical reversion? and 2) will a normal mechanism be maintained for a sufficiently long time? Cardioversion has no place in the treatment of brief paroxysmal arrhythmias, recurring ectopic beats or deranged atrioventricular or intraventricular conduction. It is without effect when the mechanism is sinus tachycardia, a reflex physiological acceleration of the normal pacemaker which does not yield to antiarrhythmic measures. Digitalis-induced rhythm disorders similarly are impervious to cardioversion. Furthermore, in the presence of digitalis toxic arrhythmias, more serious and even fatal disorders of the heart beat may result.

A number of patients are poor candidates for cardioversion because, though sinus rhythm can be established, it cannot be maintained. When quinidine is not tolerated and adverse reactions follow procaine amide, a normal rhythm will not persist. Patients with rheumatic heart disease who have been in continuous atrial fibrillation for more than two years or those with advanced degrees of mitral regurgitation who display a giant left atrium are unlikely to remain in sinus rhythm long enough to justify cardioversion. The elderly asymptomatic pa-

tient with coronary artery disease and atrial fibrillation who exhibits a slow ventricular rate prior to digitalization is an unsuitable subject. Patients who have recurrent paroxysm of diverse atrial arrhythmias should not be reverted once they develop atrial fibrillation. They are less symptomatic with atrial fibrillation than when in sinus rhythm punctuated by frequent paroxysms of tachycardia. Patients should not be reverted before, during, or immediately after valvular operations. It is preferable to wait for 10 or more days after surgery since sinus rhythm is then more likely to be long lasting.

Overall Results

To date at the Peter Bent Brigham Hospital, 900 patients have been reverted by means of cardioversion. Chronic atrial fibrillation accounted for 650 of these episodes; 150 had atrial flutter and the remaining 100 had either ventricular tachycardia or varying supraventricular mechanisms. The overall success rate was 95 per cent. These results are the more impressive, since the arrhythmia in many of these patients had proved refractory to large doses of antiarrhythmic drugs. More than 2,000 electrical shocks were employed; yet, there was not a single episode of prolonged cardiac asystole and but one episode of ventricular fibrillation due to a failure to synchronize the shock. Although many of the patients were in critical condition and a number had sustained acute myocardial infarction and were in far advanced stages of congestive heart failure, none died as a result of cardioversion. Serious immediate complications were limited to 10 episodes of ventricular tachycardia. These were of brief duration and readily controlled. Eight of the patients suffered systemic thromboembolic complications within one to eight days following cardioversion.

Specific Rhythm Disorders

Atrial fibrillation is the most common chronic disorder of the heart beat. One is no longer justified in using quinidine for reversion of this disorder. With quinidine, even when given in large doses, only 50 per cent of patients are restored to sinus rhythm; however, 30 per cent experience significant toxic reactions and 1 to 2 per cent may die from the drug. With cardioversion, atrial fibrillation can be terminated in more than 90 per cent with an incidence of complications not exceeding one per cent.

Immediately after the cardioversion discharge, there may be transitional mechanisms consisting of modal rhythm, a shifting pacemaker, and ectopic atrial beats. These are observed in about 50 per cent of patients and continue for 30 to 60 seconds until the sinus node "warms up." With restoration of sinus rhythm, the ventricular rate is slowed. The

CARDIOVERSION / Lown

PR interval is generally full and not infrequently first degree heart block is present. The overall hemodynamic state is improved with a rise in cardiac output by about 30 per cent. The most salutary effects are observed in patients who are afflicted with mitral and aortic valvular insufficiency. Maintenance quinidine therapy has to be continued in an adequate dose of at least 1.2 gm. daily which results in blood level of about 3 mg. per litre. Even with this dose of quinidine, atrial fibrillation will recur within six months in 50 per cent of patients.

Atrial flutter is best treated with cardioversion. It is the easiest disorder to terminate electrically. The arrhythmia generally responds to a single low energy shock of as little as one to five WS. No serious complications have been encountered.

Supraventricular tachycardias often present complex diagnostic and therapeutic problems. Frequently, it is difficult to define the mechanism precisely whether it is of atrial or nodal origin. More important is to determine whether digitalis glycosides are responsible for the disordered rhythm. If the arrhythmia is due to digitalis intoxication, electrical shock may provoke lethal disorders of the heart beat. When, however, small energies are employed and lidocaine is used to abolish ventricular ectopic beats, the supraventricular arrhythmias can be safely treated with cardioversion. The success rate, however, is only 70 per cent.

Ventricular tachycardia responds well to antiarrhythmic drugs such as procaine amide and lidocaine and these constitute the preferred therapy. When the arrhythmia, however, is accompanied by significant hypotension, or the patient is in pulmonary edema, or the tachycardia has developed in the wake of acute myocardial infarction and does not yield immediately to a bolus injection of lidocaine, cardioversion should be employed promptly.

Complications

The major complication following cardioversion of chronic atrial fibrillation is systemic or pulmonary embolism. This occurs in 1 per cent of patients who have not received anticoagulant drugs. If the reversion is elective and the underlying disease is rheumatic valvular, pretreatment with anticoagulants for two to three weeks is indicated. Aside from thromboembolism, atrial and ventricular arrhythmias may complicate the cardioversion procedure. The atrial mechanisms generally are of three types: 1) delayed warm-up of the sinus node manifested by sinus bradycardia, nodal rhythm or escape beats—the so-called “somnolent sinus node syndrome,” 2)

increased atrial automaticity demonstrated by single or multiple atrial premature beats at times associated with brief salvos of tachycardia and 3) “sick sinus node syndrome,” a defect in the elaboration or conduction of the sinus impulse characterized by chaotic atrial activity and usually followed by prompt re-establishment of atrial fibrillation.

The ventricular arrhythmias complicating cardioversion are less common but more threatening than the atrial disorders. These are of two types: ventricular fibrillation, which occurs immediately after delivery of the shock and usually is the result of improper synchronization; the second type develops after several beats or within a few minutes and consists of bigeminy or multifocal ventricular ectopic beats which may result in ventricular tachycardia or rarely in ventricular fibrillation. These later arrhythmias are generally associated with excessive digitalis. Lidocaine, in one or more injections of 50 mg. intravenously, is promptly effective.

Conclusion

The method of cardioversion is simple and direct. The physician can observe the entire process of reversion. It does not require a great investment of physician or patient time and is applicable to diverse arrhythmias. Differentiation between ectopic disorders, essential in the use of drugs, ceases to be a critical requisite for effective therapy.

Cardioversion is not accompanied by significant occurrence of serious complications. There is no depression of contractility, conductivity or excitability of the heart—a common sequel after large doses of antiarrhythmic drugs. The method of cardioversion can be readily mastered by the general physician.

CONSTRUCTION ON HOSPITAL AHEAD OF SCHEDULE

Construction of the new Clayton General Hospital on Upper Riverdale Road in Riverdale, south of the Atlanta Municipal Airport, is proceeding ahead of schedule. It will be a 150-bed general medical and surgical hospital with an additional allowance for inpatient mental health facilities. A temporary executive committee has been formed and is now active. Over 30 applications for staff memberships have been received and more are being received daily. Additional applications, including applications for Pathologists, Radiologists and Anesthesiologists, are welcomed. Application forms may be acquired by contacting either Mr. J. Fred Gunter, administrator, South Fulton Hospital or Dr. J. Watts Lipscomb, temporary chief of staff.

Treatment of Mental Illness in a Private Psychiatric Hospital

MARK A. GOULD, M.D., *and*
RONALDO BARRIOS, M.D., *Smyrna*

DURING THE PAST DECADE, private psychiatric hospitals have gained greater responsibility and use for the treatment of emotional disturbances. This growth in use and importance relates to the fact that private facilities have distinct advantages in patient care. In addition to quality of care, private facilities offer advantages of proximity to the patient's family, the availability of follow-up in the patient's home community and the avoidance of stigma attached to state institutions. In fact, lack of stigma attached to "mental institutions" and shortened terms of hospitalization, in many cases, are the determining factors for the patient's choice of a private hospital facility. Consequently, treatment programs in the private psychiatric hospital are goal-directed to early stabilization and control of the patient's symptoms and return to the community as soon as possible.

Implementation of this treatment program calls for specific and integrated modes of therapy which consider the patient's status, individual needs and his interactions with other individuals. Thus, the approach to treatment in our facility is eclectic so that, while emphasis is placed on individual and group psychotherapy, chemotherapy may be employed as an adjunct to the overall psychotherapeutic program. In this type of program, group and individual psychotherapy are used primarily to explore the causes of the emotional illness and redirect the patient's thoughts which emanate from the illness. Psychoactive medications, such as tranquilizers and mood elevators, are employed to control behavioral disturbances which interfere with the psychothera-

peutic program and specific activities such as occupational and recreational therapies. From experience with these medications, it has been noted that concomitant use of selective drugs sometimes provides better control of target symptoms than individual agents. For example, a combination of phenothiazines will often more effectively control agitation with fewer side effects than would a single agent used in a larger dose. A decision is often made to use more than one drug with the result being that the multiple use of selective drugs benefits the patient and shortens his stay in the hospital.

Material and Method

This study concerns treatment of 110 patients (28 males, 82 females) who manifested a variety of mental disorders including schizophrenic reactions, involutional psychotic reactions, psychoneurotic reactions, and organic brain syndromes. The age of patients ranged from 13 to 84 years with a median age of 36. Soon after they were hospitalized, the patients received psychiatric and physical examinations which included appropriate laboratory studies. Personal data, overall symptomatology, and other pertinent information were recorded for each patient as base-line data. A global evaluation of each patient's illness was made by a psychiatrist and rated as "mild, moderate or severe." These ratings were also applied for post-treatment evaluation of overall illnesses.

Diagnosis and evaluation of the patients revealed a need for control of aberrant behavioral manifestations (e.g. restlessness, anxiety, nervous

tension, depression, apprehension, confused states) which were associated with their psychiatric disorders. As stated previously, a range of concomitant psychoactive medication was selected according to requirements of individual patients. In this series of 110 patients, thioridazine, a drug shown to be useful in the therapy of various psychiatric conditions,¹⁻⁴ was used most frequently, either alone or in combination with other drugs. The severity of each patient's illness and his requirement for various drugs determined the initial dosage of each chemotherapeutic agent used, either alone or in combination. After stabilization of overt symptomatology, maintenance doses were established according to the individual condition of each patient.

Results

A comparison of the pre- and post-treatment estimate of the patient's degree of illness showed that 73 (66 per cent) improved as a result of the comprehensive treatment program. An account of improvement by diagnosis appears in Table I where it can be seen that treatment produced best results (percentage of patients improved) in schizophrenic disorders and involutional psychotic reactions.

Table II records the change in severity in illness before and after treatment at the hospital. The progress made by the patients from the "Before Treatment" groups can be determined by reading the number of patients in the "After Treatment" categories. As indicated, 77 per cent of the severely ill patients improved after treatment while 50 per

TABLE I RESULTS BY DIAGNOSIS			
Diagnosis	No. of Patients	Improved	Unimproved
Schizophrenic reaction (schizo-affective type)	30	20	10
Schizophrenic reaction (all other types)	11	10	1
Involutional psychotic reaction	19	15	4
Psychoneurotic reaction	18	9	9
Chronic brain syndrome	13	7	6
Affective reaction	8	7	1
Acute brain syndrome	5	2	3
Paranoid reaction	3	0	3
Personality disorder	2	2	0
Mental deficiency	1	1	0
Total	110	73	37

cent of the moderately ill did so. Thioridazine appears to be more effective in management of the more severe behavioral problems than in the milder disorders.

Table III contains the listing of the number of patients who obtained relief of target symptoms after treatment. The table shows that at least 50 per cent of the patients listed obtained relief of their symptoms. The predominant symptoms of restlessness, anxiety, nervous tension, and depression responded well to treatment. They were alleviated in 65 per cent to 73 per cent of the patients in whom they were initially seen. The relief of depression was particularly noted in the older patient in whom the relief of the symptom of tension was accompanied by an elevation of mood.

TABLE II ESTIMATE OF PATIENTS' ILLNESS					
Before Treatment		After Treatment			Percentage Improved*
No. of Patients	Severity	Mild	Moderate	Severe	
1	Mild	1 [†]	0	0	0
43	Moderate	22 (51%)*	21 [†]	0	51
66	Severe	23 (35%)*	28 (42%)	15 [†]	77
110		46	49	15	—

* Percentage of patients in the indicated pretreatment category who improved as a result of treatment.
† These numbers represent patients whose condition did not change.

The side effects characteristic of psychotropic medications occurred in 29 patients. The effects are listed in Table IV. In some patients these untoward reactions remitted spontaneously as medication continued, while in others dosage reduction or discontinuance of the drug(s) was required.

TABLE III
NUMBER OF PATIENTS WITH RELIEF OF
TARGET SYMPTOMS AFTER TREATMENT

Symptom	No. of Patients With Symptom	No. of Patients Relieved
Restlessness	71	46
Anxiety	70	51
Nervous tension	56	39
Depression	54	37
Apprehension	51	35
Confused states	50	37
Insomnia	36	29
Crying spells	33	25
Poor impulse control	33	16
Delirium	29	23
Preoccupations	24	22
Seclusive	17	14
Hallucinations	15	13
Flight of ideas	14	11
Sadness	13	11
Violent outbursts	13	8
Tremors	13	6
Overtalkative	12	9

Discussion

One of the advantages of treatment in this type of private setting is that of a maximum opportunity for individualized care and attention. This hospital can accommodate 50 resident patients, all on a voluntary basis, who may be admitted for a variety of psycho-social problems. Although the majority of the patients are from the Metropolitan Atlanta area, some referrals are from throughout the Southeast. Admissions to the hospital average over 500 patients each year with the average length of stay being about one month. All modalities are aimed at shortening the term of hospitalization and restoring the patient to a productive place in life.

The hospital operates as an open ward and the admission of patients is on a voluntary basis. There is a favorable staff-to-patient ratio which permits a dynamic therapeutic approach to be selected and implemented for each patient. Psychotherapy, both individual and group, is the primary mode of treatment. Electro-shock therapy is used in selected instances and a large number of patients receive psychoactive agents during their hospitalization.

The psychotropic drugs, for the most part, have been found to be effective in producing rapid relief

of most psychotic and some neurotic symptomatology. It has been our experience that thioridazine has been found to be particularly effective for the control of hyperactivity as seen in affective disorders. This agent has been particularly helpful in the management of hypomania and agitated depression, agitation accompanying involuntal problems, and the organic brain syndrome. It has been our observation that thioridazine often elevates the mood of older patients when it has alleviated the agitation and, in our opinion, it has exhibited what might be called an indirect anti-depressant effect. Impressions of an anti-depressant effect have been reported by others. Overall et al.⁵ reported on the anti-depressant qualities of this drug in a controlled, triple blind study which showed thioridazine and imipramine to be equally effective in depressed patients who manifested anxiety as a major symptom. Reviewing other comments on the anti-depressant potential of this drug, Cohen⁶ concluded that thioridazine might well prove useful in mixed neurotic anxiety-depressive states as well as psychotic agitated depressions.

Varied Relief

It has been our experience that, like other phenothiazines, thioridazine seems to have a specificity for certain target symptoms in selected individuals. It should be noted, however, as is with the case of other compounds of this class, that the ability to alleviate specific target symptoms will vary from patient to patient. Whereas one phenothiazine might not relieve a certain symptom in a specific patient, another agent might achieve this relief. We do know, however, that thioridazine has been well received by certain patients who had frustrating experiences on other agents and finally realized symptomatic relief in response to this drug.

In our opinion, thioridazine has proved to be a worthwhile drug in our program which employs si-

TABLE IV
UNTOWARD REACTIONS OCCURRING IN
PATIENTS TREATED WITH ONE OR
MORE PSYCHOTROPIC DRUGS

Side Effect	No. of Patients
Drowsiness	10
Hypotension-dizziness	7
Increased agitation	3
Dry mouth	3
Increased restlessness and confusion	1
Insomnia	1
Tremor	1
Lactation	1
Depression	1
Photosensitivity	1

multaneous use of several psychoactive agents. Although it is not a panacea for problems encountered by the general psychiatrist, it certainly does have the quality of an agent which should be included in the armamentarium of the physician practicing general psychiatry. It has been well tolerated in moderate dosages over a period of time and appears to be compatible when used in conjunction with other tranquilizers. Patient acceptability was good when this drug was administered alone or in combination, in that the number of side effects recorded was low. We have also had encouraging results in patients who have taken thioridazine over an extended period of time after discharge from the hospital.

Summary

The usefulness of treatment with thioridazine alone or in conjunction with other psychotropic agents as an adjunct to the integrated therapeutic program of a private psychiatric hospital is described. Best treatment results were seen in schizophrenic reactions, involutional psychotic reactions, and the management of the chronic brain syndrome. A number of patients who showed no improvement with previously administered psychotropic agents obtained effective relief from symptoms such as restlessness, anxiety, nervous tension, depression, confusion and crying spells, when given thioridazine alone or in conjunction with other psychoactive drugs. Side effects characteristic of psychotropic drugs were encountered in 29 of 110 patients treated.

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AAP ANNUAL MEETING SET FOR OCTOBER 18-23

In-depth presentations on child care—a national challenge, new considerations in the diagnosis and management of neonatal jaundice, key issues in infant mortality, multiphasic screening for pediatric patients, and current developments in objective means of diagnosis and therapy in allergic disorders, will be discussed during the 38th annual meeting of the American Academy of Pediatrics in Chicago, Oct. 18-23.

More than 4,500 persons including pediatricians, their families and guests are expected to attend the meeting in the Palmer House Hotel.

Additional timely scientific subjects will be presented during meetings of the Sections on Allergy, Anesthesiology, Cardiology, Child Development, Diseases of the Chest, Military Pediatrics, Pediatric Pharmacology, Public Health Pediatrics, and Surgery.

Seminars Featured

The meeting will also feature numerous seminars, round tables, and a full schedule of motion picture films.

A special one-day conference for pediatricians and pediatric nurses will also be held during the annual meeting. This conference will enable pediatricians and nurses to discuss cooperative approaches and potential programs for meeting patient care needs.

Hospital conferences at the Loyola University School of Medicine, the Michael Reese Hospital, and the University of Illinois School of Medicine, will be held on Thursday afternoon, Oct. 23.

POSTGRADUATE COURSE FOR NURSES

The third annual Postgraduate Course for Emergency Room Nurses will be conducted September 25-27, 1969, in the Palmer House Hotel, Chicago, George T. Anast, M.D., program chairman, announced.

The three-day course will be held this year in the Palmer House to allow expansion of enrollment to 1,000 nurses, not only those assigned to hospital emergency rooms but also nurses who meet emergency injury situations in their affiliations with industry and schools, Dr. Anast said.

Distinguished specialists will comprise the faculty for a curriculum which will include formal lectures, audio-visual presentations and a series of seminars to give nurses an opportunity to pursue various subjects of particular interest.

Advance registration is required and should be accompanied by the tuition fee of \$60 which covers three full days of scientific sessions and the chairman's reception and banquet. Registration fees and inquiries may be addressed to Dr. Anast at 55 East Washington Street, Chicago, Illinois 60602.

Medical Association of Georgia

Incoming President's Address

JOHN KIRK TRAIN, M.D.

WE ARE TOLD THAT HISTORY is a prelude to the future. If this be true, then we have a rich and meaningful future for the Medical Association of Georgia . . . a future that can only challenge the best in each of us. It is inspiring for me to look back on the history of this Association and the profession which founded it, and see the things which we have achieved, and see how each step, each activity, each accomplishment has contributed to what we are today.

Becoming your president is an awe-inspiring challenge. I can assure you that against medicine's background of success and with your help and the welcomed assistance of my predecessor, Charles Andrews, who has done so much, I will do everything in my power to earn your confidence and maintain that direction of MAG which I feel has been right.

Those who write history are oftentimes not the ones who made it happen. It shall be my objective, with the help of each member of this Association and with the invaluable aid of our fine staff in Atlanta, to see that a history of increased service by MAG to its members and to the public is written. The Medical Association of Georgia stands on a firm foundation laid decades ago; the framework was built in the fast-moving intervening years. The decade just past has been an epochal one for us; more changes have occurred than in any similar period of the past. It has been a decade of turbulence, discord, disunity . . . a period in which the things which have made this nation great have been questioned—a period in which we have faced many crossroads in our own beloved profession, and are continuing to face them daily. Who could dream 10 years ago that a young man in Houston, Texas, and others around the world would be able to renew the lives of human beings in such a dramatic way . . . and who could dream of the

questions they would raise? Who could dream 10 years ago that we would reach today's level of third party payments in this country, the seat of free enterprise and individual responsibility?

Great Strengths

We in medicine have looked at ourselves and we have found great strengths. We've also found we need some up-dating and modernizing, yet never losing sight of the high ideals and principles which are the bedrock of our profession.

Medicine's advances have been truly wondrous to behold. The criterion most universally used in evaluating medical progress is the comparative measure of the life span of man from one period of time to another. I think it is well to use this yardstick, for the expectation of added years of life serves as the most accurate as well as the most vivid testimonial that the diseases of mankind are being subjected to greater and surer control. It is the absolute vindication of the continuing progress of medical science. At the time of the American Revolution, the life expectancy of the average American was 35 years. By 1900 the average man could expect to live only to an age of approximately 47.3 years. But in the 20th Century the expectation of longer life spurted higher. By 1915, it had jumped to an even 50 years; by 1937—60 years; and by 1960—about 70 years. And now, the child born today can expect to live more than 24 years more than his grandparents if they were born in the year 1900.

What of tomorrow? Taking into consideration our present scientific knowledge and the potential of future developments, it is not at all unrealistic to believe that American babies, born not too many years from now, may well be the first generation to live an average of 100 years or more.

Golden Age of Medicine

It is reasonable to say that since 1900, we have been well embarked on our golden age of medicine. In our own life time we have seen the traffic of the student of medicine turn from Europe to our own shores. We have experienced the discovery of the means to curb such dread killers as pneumonia, tuberculosis, poliomyelitis, through the development of operating skills undreamed of, and now we are beginning to see the results of the concentrated war on heart disease and cancer. Indeed we have seen in our lifetime more progress in medicine than all the previous centuries combined. Medical minds are edging ever closer to the challenges imposed by arteriosclerosis, mental illness, mental retardation, neurological and sensory diseases, and deaths associated with childbirth. We are in the first stages of tissue and organ transplantation in humans, and vast new vistas will be opened from these beginning experiments. I would say that the major emphasis today in our research and clinical laboratories centers properly on arteriosclerosis, the number one cause of death, and cancer, presently the number two cause of death. This is not to imply that work in the other areas I have mentioned has been suspended or lagging; I merely state that arteriosclerosis and cancer are our two greatest killers at the present time and immediate attention and substantial study of these diseases are deserving. We know from statistical evidence that there will be more than a half million new cases of cancer diagnosed in this country alone this year, and we can expect that approximately 300,000 persons will die from this killer. But we also know that 25 years ago we were able to save only one in five patients with cancer; today we are saving one in three. Furthermore, we can probably say with accuracy that if the knowledge of today concerning early diagnosis and proper treatment could be made available to every man, woman and child in the country, we could save one out of every two patients afflicted with cancer.

Continuing Progress

The very fact that we can spout these statistics with such painful accuracy is a reflection, ironically enough, of our medical progress. And the progress continues.

We have recognized changes in life and living in this nation, and with resources, determination and manpower, have moved into the pockets of medical need with programs that are meaningful and challenging . . . daring to fail if we must, in an effort to find the right way to give the millions of persons there, who might be in need of medical care, the rich rewards of our progress.

The injection of the Federal Government into the field of health care as a third party has, of course, reached epic proportions in the recent decade and placed tremendous pressure and responsibility on the medical profession to give proper leadership and guidance to these programs which affect us all. This we have done well in Georgia. Many states are now envious of the fine position we occupy in our relationships with the Government programs, including Medicare and the John Hancock Company; Medicaid and

the Travelers Company; our own CHAMPUS or Military Medicare; Model Cities, etc. And many states are looking to us with an envious eye because of our position in the Regional Medical Program for heart, cancer, stroke and related diseases. Our GRMP Program was recently cited as one of the top 10 RMP programs in the country and MAG members can be proud that this organization took a leadership role in this program at the outset. This same pattern of leadership has been displayed in those who have been involved with the Comprehensive Health Planning Council for Georgia, and more recently in the newly formed MAG Committee on Areawide Health Planning.

Firm Foundation

Yes, we have a firm foundation . . . we have a strong framework and now it is time we look at the next stage in expanding our organization that we all respect and in which we participate. What are our overriding needs in meeting our responsibilities? I see several demanding our immediate and total attention. First, we need to be more relevant today, and to look with extended vision to the next 15 to 20 years to see that we stay ahead of the needs and concerns of our organization and its place in the community. We need to be flexible. Look at what is taking place in the area of health careers as an example. We have already voted to contribute, on call, \$5,000 to the new Health Careers Council of Georgia. We took this action after the Hospital Association had taken a similar action, but the Hospital Association has also added a Department of Health Careers to its office staff and is doing a creditable job in this area on its own. Their program has only one flaw in it, and that is that their literature never mentions medicine as one of the careers they are promoting. When questioned about this oversight they advised us that they assumed that we would take the leadership in that area and do more toward physician recruitment than they would be able to do. Our \$5,000 has not been called in, no staff has been hired by the Health Careers Council, and our present staff is not able to do much more than route films and literature to those physicians who are asked to do a program in their local school. Consequently, not much in the area of physician recruitment is being done at this time. I mention this only to point up the fact that we need to be flexible and when problems of this kind are recognized by us or by our staff, we will have the resources to react in a meaningful and effective way.

Continuing Education

Another area of recent attention is that of continuing education. What should be the role of our state medical association in this important area? This seems to me to be another staff responsibility that we should prepare to assume, when the day comes that record keeping and other chores in connection with a continuing education project are a necessity. I call on each of you to take with me a forward look. We are big enough, in all the meaning of bigness. . . . We are strong. . . . We are capable enough . . . to move forward in all these areas. You will see in Charles Andrews' report the many "firsts" which characterize his

year as president of this organization. Let ours be a year in which we will see these programs expanded and in many cases brought to a successful conclusion. Let me here and now challenge each of you to these responsibilities:

Responsibility to your God. Good atheists may become physicians, but a belief in God and a feeling of reverence for the soul of the patient as well as concern for the body of the patient, will make us all better physicians.

Responsibility to the public. Let us be well trained in our chosen field and take the time and put in the effort to keep up with the rapid advances of medical progress.

Responsibility to the community. Physicians continue to be among the most admired and respected of professionals. Physicians should exert their influence for community good.

Responsibility to our families. A doctor's time is often not his own, but he owes it to his wife and

family to find the hours each week for his family's well being and peace of mind.

Responsibility to organized medicine. Accept with me the task of seeing that through MAG and its local societies we successfully represent all physicians in this great state. Success builds a proud and contented corps, and success is predicated on people knowing what they are to do, how they are to do it, and finding confidence in their accomplishments. Getting the job done will require adequate planning (which we will accomplish at the committee conclave in July), commitment to realistic goals and objectives, membership growth, membership activity and sufficient dollars and staff as said above. We need to be flexible; in our case flexibility means men and women, the members of MAG and its staff and money to help turn their thoughts into action. We live in a new day, a fast moving one, with its unique challenges and special opportunities. Tomorrow will move even faster.

CALENDAR OF MEETINGS

In Georgia

Sept. 11-13—Eighth District American Society of Anesthesiologists Meeting, Atlanta.

In the Nation

Aug. 21-22—AMA Communications Institute, Drake Hotel, Chicago, Ill.

Aug. 24—American Association of Nursing Home Physicians, Shoreham Hotel, Washington, D.C.

Aug. 24-29—American Geriatrics Society, Sheraton-Park Hotel, Washington, D.C.

Sept. 2-6—International Tuberculosis Conference, Waldorf Astoria Hotel, New York, N.Y.

Sept. 4-6—American Association of Obstetricians and Gynecologists, The Homestead, Hot Springs, Va.

Sept. 11-16—Council on Occupational Health, Stouffer Riverfront Inn, St. Louis, Mo.

Sept. 14-20—International Congress of Electroencephalography and Clinical Neurophysiology, El Cortez Hotel, San Diego, Calif.

Sept. 14-20—College of American Pathologists, Palmer House, Chicago, Ill.

Sept. 16-20—Congress of Neurological Surgeons, Sheraton-Boston Hotel, Boston, Mass.

Sept. 19-20—Council on Drugs, AMA Headquarters, Chicago, Ill.

Sept. 19-21—Council on Legislative Activities, Boston, Mass.

Sept. 21-25—International Symposium on Comparative Leukemia Research, Cherry Hill Inn, Cherry Hill, N.J.

Sept. 21-27—World Congress of Neurological Sciences, New York Hilton, New York, N.Y.

Sept. 26-Oct. 3—American Academy of General Practice, Philadelphia, Penn.

Sept. 29—Society for Pediatric Radiology, Washington Hilton Hotel, Washington, D.C.

Oct. 6-10—American College of Surgeons, Fairmont Hotel, San Francisco, Calif.

Oct. 8-11—National Hemophilia Foundation, Drake Hotel, Chicago, Ill.

Oct. 8-11—National Conference on Physicians and Schools, Pick-Congress Hotel, Chicago, Ill.

Oct. 11-12—American Association of Ophthalmology, Palmer House, Chicago, Ill.

Oct. 12-17—American Academy of Ophthalmology and Otolaryngology, Palmer House, Chicago, Ill.

Oct. 12-16—American Society of Plastic and Reconstructive Surgeons, Chase-Park Plaza, St. Louis, Mo.

Oct. 18-23—American Academy of Pediatrics, Palmer House, Chicago, Ill.

Oct. 25-29—American Society of Anesthesiologists, San Francisco Hilton, San Francisco, Calif.

Oct. 29-Nov. 2—American College of Chest Physicians, Palmer House, Chicago, Ill.

Oct. 31-Nov. 3—Association of American Medical Colleges, Netherlands Hotel, Cincinnati, Ohio.



THE NC-4 TO THE C5-A

IN MAY OF THIS YEAR was celebrated the 50th anniversary of the crossing of the Atlantic by the NC-4, and in May of this year test flights of the C5-A were continued in North Georgia. The NC-4 as many may not recall was the latest thing in aircraft in 1919; it was a prototype seaplane of which four were built for the U.S. Navy in an attempt to find a plane that could fly across the Atlantic Ocean. Three of these planes left the United States in May, 1919, for the transatlantic flight, with stops scheduled in New Foundland and the Azores; one plane was lost at sea, one taxied on the ocean the last 200 miles to the Azores, and one, the NC-4, made it to Portugal some three weeks after leaving home, the first successful transatlantic flight. The figures and statistics of the C5-A should be familiar to all Georgians, with its tremendous size designed to carry large numbers of troops anywhere in the world at supersonic speeds, making the wheatfields of the midwest U.S. part of the field of action in a war anywhere in the world, the last word in aircraft today.

Now, while the speed of planes was being increased from 70 miles per hour to supersonic, the open cockpit was being replaced by the pressurized cabin, and other developments in air flight were taking place during the past 50 years. The art and practice of medicine has changed just about as much; the horse and buggy, famed in fable and fiction, were no longer in use, at least not in the cities fifty years ago, but the doctor's transportation was by hand-cranked jalopy. The only method of air conditioning was to leave the curtains down and let in some of the, in those days, unpolluted air; and this jalopy has given way to the air-conditioned sedan of today. Diagnosis in those days was by seeing, listening, feeling, and, so they say, even by smelling; none of our present diagnostic aids needed so much today was available and the technique of "We'll give a broad spectrum antibiotic and some intravenous fluids tonight and see how things are in the morning" had not yet been developed. Today we live in a great medical age; many illnesses present in the days of the NC-4 no longer to be feared. A recent roadside sign that came to my attention saying "The good old days are now" had a ring of truth to it.

But what of the next 50 years of medicine, at which time the C5-A will be regarded as an antiquity, as the NC-4 is today? The tomorrow of medicine has already begun, with organs being transplanted, new blood vessels replacing old sclerotic ones, physical defects of the as yet unborn being diagnosed and treated, and many other explorations into the "outer space" of medicine in the developmental stages. The young man or woman starting on a career in medicine today will, without doubt, look back and wonder how they made it in the 60's and 70's with only the knowledge we have today, and the little old C5-A.

A handwritten signature in cursive script that reads "John Kirk Train". The signature is written in dark ink and is located below the main body of text.

*John Kirk Train, M.D.
President, Medical Association of Georgia*



EPIDEMIOLOGY OF CORONARY HEART DISEASE

GLEN E. GARRISON, M.D., *Augusta*

DURING THE PAST 20 years numerous epidemiological research projects have been conducted on coronary heart disease and its relationship to a wide variety of potentially associated factors. The various methodologies used in these surveys were reviewed in the Heart Page for March 1969.

In these projects it has been conclusively demonstrated that the likelihood that currently healthy individuals will subsequently develop coronary heart disease varies *directly* with the height of the serum cholesterol, the height of the blood pressure, the height of the serum glucose, number of cigarettes smoked, presence of cardiomegaly by x-ray, presence of left ventricular hypertrophy on the electrocardiogram, and the possession of a tense deadline-oriented personality. A strong *inverse* relationship exists between the probability of developing coronary heart disease and the level of regular physical activity in one's occupation. In addition, large differences in death rates exist between various geographical regions of the United States, and these differences are predominantly produced by variations in mortality caused by coronary heart disease. For example, the age-corrected death rate in southeastern Georgia is considerably higher than in northwestern Georgia.

Diet and Disease

Upon examination of the voluminous data on the relationship between diet and coronary artery disease, the following is well documented. In international studies the general pattern is that nations having the higher coronary heart disease death rates also have the highest per capita consumption of saturated fats in the diet. Some exceptions have been noted.

High saturated fat diet is one of numerous environmental factors statistically associated with the increased likelihood for development of coronary heart disease; most of these factors are unique to the more socioeconomically developed nations (for example, high number of telephones per capita). It has been demonstrated that within individual communities people having high serum cholesterol and those having low cholesterol eat similar diets; consequently, the wide range in serum cholesterol observed in a particular community is not related to differences in

Prepared at the request of the Committee on Professional Education of the Georgia Heart Association.

dietary consumption. Finally, it has been clearly demonstrated that some reduction in serum cholesterol can be obtained by placing individuals on a diet that contains a low amount of saturated fat.

Only a limited amount of epidemiologic research has been performed on factors associated with the development of cerebrovascular diseases. However, available data demonstrates that the presence of high serum cholesterol, hypertension, and electrocardiographic abnormalities (left ventricular hypertrophy, intraventricular block, or persistent ST and T changes) are correlated directly with the subsequent development of cerebral thrombosis. Therefore, it is reasonable to conclude that the development of cerebral atherosclerosis and coronary atherosclerosis are related to at least some of the same factors. Certainly, this would not be unanticipated because the basic arterial lesion is apparently the same in the two locations.

Future Disease Development

In this article a considerable number of factors have been mentioned which relate to increased likelihood of healthy individuals subsequently developing coronary heart disease. With this information insurance companies can select or exclude candidates for insurance or set differential premium rates with confidence based on the prognosis for individuals having various findings. To a considerable degree, information in these categories is currently being utilized by insurance companies for this purpose. Group risks can be determined with considerable confidence. However, accurate determination of risk for particular individuals within the various groups is considerably less accurate because of the well-known variation in prognosis which exists among individuals having similar findings.

The most important reason for conducting the various epidemiologic studies which have obtained this information is to identify factors which, when modified or removed, will produce improved health for individuals in the future. Documentation of the association of a factor with coronary heart disease is only the first step. The second step is to identify those associated factors that can be successfully and safely modified. The third step is to determine if a specific modification of a factor produces an improved prognosis for the individual's health. The documented importance of treating hypertension was presented in the Heart Page in April 1969. During the next several months the potential advantages of modifying other factors statistically associated with the development of coronary heart disease will be discussed in the Heart Page.

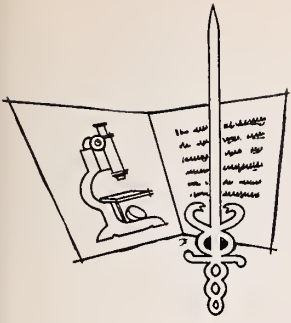
Medical College of Georgia

GaMPAC WORKSHOP

**Royal Coach Inn, Atlanta
(I-75 at Howell Mill Rd., N.W.)**

OCTOBER 11, 1969

All Physicians & Wives Invited



INGUINAL HERNIA AND COLON CANCER

PANO A. LAMIS, M.D., *Atlanta*

THERE IS A SURGICAL AXIOM in training programs that an elderly patient with an inguinal hernia needs three things preoperatively: a chest x-ray, evaluation of the prostate, and a barium enema. Pulmonary pathology and obstructive uropathy certainly should be considered as possible predisposing diseases. At this writing, however, I wish to emphasize the association of colon carcinomas and inguinal hernias in these patients.

There have been several reports stressing the fact that these are frequently co-existing entities in the elderly.^{1, 3} It is important, therefore, to periodically re-emphasize these findings. In a study by the U.S. National Health Survey, a significant increase in the number of inguinal hernias in older patients with carcinoma of the colon was revealed.² In the age group 55-64 years, 27.5 per cent of the patients with colon carcinoma had inguinal hernias, whereas the incidence of hernias in the general male population of that age was only 5.2 per cent. In the age group 65-74 years, the incidence of these two co-existing problems was 25.9 per cent as compared to the expected 8.7 per cent.

A recent series showed that out of 303 patients who had colon cancers, 68 or 22.4 per cent were found to have an inguinal hernia at the time of admission to the hospital or had undergone a herniorrhaphy within the prior two years. Approximately 80 per cent of these patients were over the age of 55 years. At one hospital where routine proctosigmoidoscopies and barium enemas are performed in patients over the age of 55 before elective hernioplasty, six previously undetected colon cancers were discovered in a one year study period. These patients had no complaints referable to the colon cancers and were hospitalized for treatment of their hernias.

Increased intra-abdominal pressure may be produced by an underlying colon lesion due to straining on defecation or partial intestinal obstruction. This condition may be a precipitating factor in the appearance of an inguinal hernia in the adult. Abdominal pain is often the chief complaint of patients with colon cancer and when an inguinal hernia is present, the cause of the pain may be misdirected to the hernia. Inguinal hernias in the elderly man are certainly not uncommon; however, when the hernia appears to be of recent onset, of recent symptomatology or of recent recurrence, the probability of an associated colon or rectal lesion is

increased. The statistical evidence is convincing and in view of the rising general population age, the knowledge of this relationship is of significant importance. It is incumbent upon the physician and surgeon therefore to remember this surgical axiom in treating the elderly patient. In the preoperative evaluation, a barium enema is desirable and a proctosigmoidoscopic examination mandatory prior to elective hernia repair.

340 Boulevard, N.E.

REFERENCES

1. Davis, W. C. and Jackson, F. C.: Inguinal Hernia and Colon Carcinoma. *Ca* 18:143, 1968.
2. Health Statistics from the U.S. National Health Survey, PHS Publication No. 584-B25, Washington, U.S. Government Printing Office, 1960.
3. Maxwell, J. W., Jr., Davis, W. C. and Jackson, F. C.: Colon Carcinoma and Inguinal Hernia. *Surg. Clin. of N. Amer.* 45:1165, 1965.

ALCOHOLISM STUDY CALLS FOR COMMUNITY TREATMENT CENTERS

A detailed study on alcoholism in Georgia prepared at the request of the State Board of Health and just released by the State Health Department places strong emphasis on the establishment of community alcoholic treatment centers to find and treat some 90,000 alcoholics in the state who are receiving no type of care.

In a joint statement commenting on the study, Board Chairman B. W. Forester, M.D., of Macon and State Health Director John H. Venable, M.D., said, "The problem of alcoholism in our state as well as the nation is becoming a major chronic illness. There are many Georgians with this illness who can and should be helped before they reach the point of no return.

"This recently completed study which indicates the magnitude of the problem now gives us a guide to begin an all-out campaign to find and help the Georgians who need professional care," the statement said.

The report has 37 recommendations for mapping a plan to conquer alcoholism in Georgia. One of the major recommendations calls for the development of more community-based alcoholic treatment centers. These centers are to be a joint effort by private and public agencies in the community.

"Less than 10 per cent of the state's alcoholics are under treatment today," said Charles Methvin, chairman of the study group. "There are some 100,000 alcoholics in Georgia today. One of our major problems is locating these people and getting them to recognize their problems.

"Seeking out these people and helping them to recognize their problem can most effectively be done on

local levels with the cooperation of the whole community," he continued.

To illustrate this point, he said that each alcoholic directly affects the lives of four other people—mainly the alcoholic's immediate family—and up to 10 others indirectly, including the alcoholic's business and social associates.

Methvin, who is also serving as coordinator of community alcoholism programs for the State Health Department, said that the community programs would work closely with general hospitals when feasible and practical. "At present," he said, "we have 10 community-based out-patient clinics in the state. We will need at least 25 within the next five years if we are to continue the present progress in Georgia."

He also stressed that community programs would be the "front line of defense" in preventing and treating alcoholism. And these programs would be backed by the state's regional mental hospitals and training and research activities of the Georgian Clinic in Atlanta.

The alcoholism study also calls for legislation that would permit emergency involuntary admission of an intoxicated person to a hospital for a period of time not to exceed 72 hours, without legal proceedings or warrant, providing that the admitting physician concurs in the need for detoxification.

Methvin said that this type of legislation would be intended to prevent the intoxicated person from harming himself or others. "What we seek is medical treatment, not jailing or punitive action of the alcoholic," he said.



TREATMENT OF MINORS

JOHN L. MOORE, JR., *Atlanta**

THE MEDICAL ASSOCIATION OF GEORGIA sponsored S.B. 179 in the 1969 General Assembly changing the law of Georgia relative to the treatment of minors for venereal disease or the suspicion of venereal disease.

S.B. 179 provided that, contrary to earlier principles of law in Georgia, a physician, hospital, clinic, or like providers of medical services could take a minor as a patient for the diagnosis and treatment of suspected venereal disease without the knowledge or consent of the minor's parents or guardian. The General Assembly passed the bill, but Governor Maddox vetoed it.

The Governor's action in vetoing S.B. 179 brings to mind once again the question, always troublesome to physicians, of the treatment of minors unattended by a parent or responsible adult. Basically, a physician may not take a minor as a patient without the consent of a parent or responsible adult guardian. Should the physician do so, except in circumstances mentioned later, he may be held liable for damages for assault and battery. Since assault and battery is an intentional tort (as compared to malpractice, an unintentional, "negligent" tort), damages may be assessed based on actual harm done together with damages sufficient to deter the defendant from similar wrongdoing in the future.

Who Is a Minor?

Under Georgia law a minor is any person not having reached his 21st birthday if he has not been emancipated. The doctrine of emancipation is quite complicated and the physician would be well advised to talk to his attorney before he treats any person under 21 years of age without parental consent.

Emancipation occurs upon marriage at the proper age with the consent of all parents involved. Emancipation can occur if the minor has lived separately for a period of time, though unmarried, is self-supporting, and if the parents either have consented to this independence or have abandoned the minor.

Who Is a Guardian?

A guardian may be appointed by the Court of Ordinary for either the person or the property of a minor who does not have parents alive and responsible for

* Mr. Moore is a member of the firm of Alston, Miller & Gaines, General Counsel to The Medical Association of Georgia. This article is prepared at the request of The Medical Association of Georgia.

him. While the guardian of the property of a minor could consent to the minor's treatment in terms of binding the minor's estate to pay for the treatment, the guardian of the person is the only proper person to give consent to the minor's treatment so as to negate assault and battery.

A "testamentary guardian" may be appointed for the person of a minor without court action. The testamentary guardian is appointed by the will of the later of the parents to die. To be safe in relying on such appointment, a certified copy of the will should be reviewed as well as proof that the testator of the particular will died after the other parent.

A court itself may take jurisdiction of a child even if the parents are alive. This jurisdiction in Georgia is conferred upon the Juvenile Court. In larger Georgia cities the Juvenile Court is usually a separate court. In other than larger cities, the Superior Court acts as the Juvenile Court. Such courts can take jurisdiction of delinquent children under 17 years of age and also of neglected or abandoned children. One ground for the Juvenile Court's jurisdiction is that the minor has been medically neglected by his parents.

Georgia statutes allow the Juvenile Court to appoint duly qualified physicians as special child guidance consultants to make examinations of the children and to treat them. The court is authorized to provide compensation to the physicians or to provide such services through the Health Department. Probation officers may shortcut long court procedures to obtain such medical assistance. It would also seem proper to this writer for any person in authority, such as a police officer, to obtain necessary medical services for a child in need. The officer's consent would probably protect the physician from charges of assault and battery although a court order would provide better protection and the police officer's consent would probably not bind anyone to pay the physician.

Emergency

The consent of parents or guardian is implied without actual contact with the parents or guardian in an emergency when immediate treatment is imperative and delay involves serious risk to the patient. Consent will also be implied if the parent knew of the preparations for treatment and did not object.

In one case the arm of a 17-year-old boy was crushed by a train. Telephone efforts to reach the parents failed. The physicians held a consultation and then amputated the boy's arm. The parents' consent was implied.

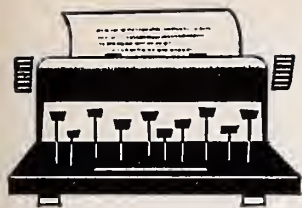
In another case two adult sisters took an 11-year-old child to have her badly diseased tonsils and adenoids removed. She died while under anesthetic. The court held the physician liable for not obtaining parental consent, saying there was no immediate emergency.

Some jurisdictions have liberalized their approach to the treatment of minors. A New York court, for example, implied consent for anesthesia for a fractured ankle of a minor 20 years, 4 months of age. The father sued for the administration of the anesthetic without his consent. The court noted that the procedure was necessary to stop needless pain and suffering.

However, it is always unwise to rely on such liberalizing decisions in a separate case. The physician should obtain parental consent if at all possible except where a real medical emergency exists. Because of the Governor's veto of the venereal disease bill, it is clear that any physician would be exceedingly unwise to treat minors for suspected venereal disease without parental knowledge and consent.

This writer certainly hopes that legislative relief may be obtained in coming years. In the meantime, he beseeches physician readers of this article not to leave his children in pain until they are able to find him.

*Suite 1220
C & S Bank Building*



Committee Conclave

IN SEPTEMBER, 1968, MAG held its first Conclave of all committees. Following that event, then-President Charles R. Andrews, Jr., M.D., obtained a critique report from each committee chairman. Those reports overwhelmingly endorsed the idea of a conclave of committees to be held soon after committees are appointed each year.

All MAG committees are appointed by the Executive Committee of Council and appointments are approved by the Council in June of each year. A meeting of all committees of MAG has been scheduled for Saturday, July 26 and Sunday, July 27, at the Marriott Motor Hotel, Atlanta. As soon as a schedule of meeting times and room assignments can be developed, each committee member will be informed as to the time and place his particular committee is to meet. Hotel reservation forms will be enclosed with the committee meeting notices. The Woman's Auxiliary Summer Board meeting and Workshop will be scheduled at the Marriott Motor Hotel so as to coincide with the Committee Conclave.

This general initial meeting of all MAG committees is designed to encourage early organizing and planning by each committee, to influence coordination of committee work, to provide adequate staff and materials, to lessen somewhat the details of arrangements and conduct of committee work when many of these committee meetings are scattered over the Society year.

No pre-planned meal functions are scheduled during the Committee Conclave. MAG will arrange a "Dutch-Treat" cocktail party for committee members and their wives on Saturday evening in the Plantation Room, Marriott, to serve as a gathering point before dinner-on-your-own.

MAG Physicians Host Georgia Congressmen in Nation's Capitol

A GROUP OF GEORGIA PHYSICIANS representing each of the State's 10 Congressional Districts made their annual pilgrimage to Washington on May 16 to host Georgia Senators and Congressmen at a luncheon honoring our elected officials in the nation's capitol.

As in years past the reception accorded the MAG delegation was warm, friendly, informative and highly productive of the close rapport so essential to the maintenance of good Congressional relations.

Under the leadership of the MAG Committee on Legislation, the 1969 annual Congressional luncheon was the 11th in as many years. Committee Chairman J. Frank Walker served as Master of Ceremonies for the luncheon and "field commander" for the trip in general.

Following lunch, Dr. Walker made brief remarks on several matters of mutual interest, including health legislation pending in the Congress and some of the highlights of the recent meeting of the MAG House of Delegates.

In turn each of the Congressmen spoke briefly on matters of topical concern that ranged from experimental aircraft to student riots to endorsement of GaMPAC and physician involvement in political affairs.

Preceding the luncheon the physicians were given a briefing by the AMA Washington Office and an opportunity to visit their Congressman in his office for a discussion of health-related legislation.

The luncheon was arranged through the good offices of Representative John J. Flynt, Jr. of the 6th District and held in the Speaker's Dining Room at the Capitol.



Seated, left to right: Hugh Thompson, M.D., East Point; Rep. Fletcher Thompson, 5th District; James A. Kaufmann, M.D., Atlanta; Senator Herman E. Talmadge; J. Frank Walker, M.D., Atlanta; John Kirk Train, M.D., Savannah; Rep. Phil Landrum, 9th District. Standing, left to right: Mr. James M. Moffett, Atlanta; Mr. Proctor Jones (Senator Russell's staff); Rep. John J. Flynt, 6th District; T. A. Sappington, M.D., Thomaston; John Meier, M.D., Albany; Bruce Newsom, M.D., Columbus; J. D. Bateman, M.D., Albany; Rep. Maston O'Neal, 2nd District; Herbert S. Alden, M.D., Atlanta; Carson Burgstiner, M.D., Savannah; Charles Andrews, M.D., Canton; Rep. G. Elliott Hagan, 1st District; Joseph A. Mulherin, M.D., Savannah; O. O. McGahee, M.D., Jesup; Luther Vinton, M.D., Decatur; Rep. Ben Blackburn, 4th District; Rep. John Davis, 7th District; Earl T. McGhee, M.D., Dalton.



THE ASSOCIATION

NEW MEMBERS

Bailey, James A., M.D. Active—Fulton—PM	69 Butler Street, S.E. Atlanta, Georgia 30303
Cooney, James P., M.D. Service—Fulton—R	938 Peachtree Street, N.E. Atlanta, Georgia 30309
Engelhardt, Samuel M., III, M.D. Active—Fulton—OBG	710 Peachtree Street, N.E. Atlanta, Georgia 30309
Fiveash, Arlie E., M.D. Active—Richmond—R	Talmadge Hospital Augusta, Georgia 30902
McDaniel, William L., Jr., M.D. Active—Whitfield—GP	Cleveland Road Dalton, Georgia 30720
Sanders, Drayton M., II, M.D. Active—Whitfield—I	Memorial Drive Dalton, Georgia 30720
Schlossberg, Michael, M.D. Active—Fulton—OBG	1996 Campbellton Rd., S.W. Atlanta, Georgia 30311
Slone, Herbert P., M.D. Active—Whitfield—PATH	Hamilton Memorial Hospital Dalton, Georgia 30720
Tennant, Harry R., M.D. Active—Whitfield—GP	120 W. Walnut Street Chatsworth, Georgia 30705
Werner, Jacqueline H., M.D. Active—Fulton—PATH	783 Woodruff Memorial Building Atlanta, Georgia 30322

SOCIETIES

The Bibb County Medical Society awarded 28 trophies to Bibb County junior high students showing the most improvement in physical fitness.

The Flint River Medical Society joined nurses and other hospital and rest home personnel in observing National Hospital Week.

The Georgia Medical Society honored its immediate past president Thomas A. McGoldrick, Jr., M.D., at a dinner in May. Corbett H. Thigpen, Augusta psychiatrist, was guest speaker.

Paul G. McDonough spoke on "Medical, Moral and Legal Aspects of Therapeutic Abortion, Sex Determination and LSD Usage in Humans" at the May meeting of the Muscogee County Medical Society.

PERSONALS

First District

Laurence B. Dunn of Savannah retired June 1 after 40 years of practice.

Third District

Thomas McCall Allen of Dawson has been elected to active membership in the American Academy of General Practice.

H. J. Peters, director of laboratories and pathologist at St. Francis Hospital in Columbus, will serve as president of the Georgia Association of Pathologists for 1969-70.

Fourth District

Jack W. Whitworth has been named Medical Director of West Point Pepperell.

Fifth District

Fred L. Allman, Jr. has received one of three top national awards in a physical fitness leadership contest sponsored by the United States Jaycees and Metropolitan Life Insurance Co.

C. Daniel Cabaniss, specialist in internal medicine and cardiology, was the principal speaker at the annual Polk County Heart Council awards meeting in May.

Alexander D. Langmuir, director of the epidemiological program at the National Communicable Disease Center in Atlanta, has received the Award of Distinction of the Cornell Medical College Alumni Association.

Mieczyslaw Peszczynski has been elected president of the Association of Academic Physiologists.

Sixth District

David E. Quinn has been honored with a plaque of appreciation from the people of Laurens County.

William E. Holladay has been elected to Fellowship in the American College of Physicians.

Noah D. Meadows, Jr., received the Liberty Bell Award from the Cobb Judicial Circuit Bar Association in May.

Don W. Schmidt has been honored by the Cedar-town Chamber of Commerce as its first Man of the Year.

Evelyn M. Stephenson has resigned as pathologist at Hamilton Memorial Hospital to continue her studies in medicine and to travel.

DEATHS

Henry James Pitt Harding, Jr.

Henry James Pitt Harding, Jr., died May 10 in Emory Hospital, Atlanta, after undergoing a kidney transplant five weeks previously.

Dr. Harding, 43, was graduated from the University of Alabama and Emory University Medical School and took his residency at Crawford W. Long Hospital in Atlanta. He practiced for a time in Columbia, Tenn., before entering practice in Columbus in 1965.

He was a member of Phi Rho Sigma medical fraternity, East Columbus Rotary Club, Muscogee County Medical Society, the American College of Obstetricians and Gynecologists, Medical Association of Georgia, and the First Presbyterian Church of Columbus.

Survivors include his widow, Mrs. Bettie Rowland Harding; his father, Col. (ret.) H. P. Harding, Sr.; a daughter, Miss Ann R. Harding, and two sons, Pitt Harding III and Christopher Harding, all of Columbus.

Guy Jackson Dillard, Sr.

Guy Jackson Dillard, Sr., 72, died June 4 at Pine Manor Nursing Home after a long illness.

A graduate of the University of Georgia and Emory University School of Medicine, Dr. Dillard interned at St. Joseph's Hospital in Atlanta and took his residency at Philadelphia General Hospital. He had practiced internal medicine in Columbus since 1925.

Dr. Dillard was a member of The Medical Center staff and of St. Francis Hospital. He was a past president of the Third District Medical Association and the Kiwanis Club of Columbus, as well as a member of the Muscogee County school board, American Society of Internal Medicine and the Big Eddy Club. He was a member of the First Baptist Church.

Dr. Dillard is survived by his widow, the former Estelle Jessup; a daughter, Mrs. J. Steve Knight, Columbus; a son, Guy J. Dillard, Jr., North Palm Beach, Fla., and 10 grandchildren.

ROSS NEW AREA DIRECTOR

Thomas L. Ross, M.D., of Macon assumed his duties as Area Program Director for the East-Central Area of the Georgia Regional Medical Program on July 1.

J. Gordon Barrow, M.D., GRMP Director, announced this new position. Dr. Ross is headquartered in Macon and in charge of the administration and operation of GRMP activities in his section of the state.

In making the announcement, Dr. Barrow stated that this area program concept will facilitate the working of the GRMP program in reaching all the people of Georgia.

Dr. Ross has been a member of the GRMP Task Force on Cardiology and Renal Diseases.

HEART ASSOCIATION TO MEET

The 21st Annual Scientific Sessions of the Georgia Heart Association will be held September 15-16 at the DeSoto-Hilton Hotel in Savannah, Georgia.

Speakers include Oglesby Paul, M.D., Chief of the Division of Medicine, Passavant Memorial Hospital, Chicago, Ill.; Benjamin Castleman, M.D., Pathologist, Massachusetts General Hospital, Boston, Mass.; Gordon Ewy, M.D., Department of Cardiology, Georgetown University Division, District of Columbia General Hospital, Washington, D.C.; Dean T. Mason, M.D., Professor of Medicine and of Physiology, and Chief of the Cardiopulmonary Section of the University of California at Davis School of Medicine, and; Rene Favalaro, M.D., on the Staff of the Department of Thoracic and Cardiac Surgery of the Cleveland Clinic, Cleveland, Ohio.

Subjects to be covered include various aspects of organ transplantation; epidemiology; cardiomyopathy; coronary care units; antianginal therapy; Beta adrenergic blocking drugs; operative procedures in indirect revascularization; prevention in coronary arteriosclerosis, and direct coronary artery surgery.

For further information, write the Georgia Heart Association, Inc., Broadview Plaza, Level C, 2581 Piedmont Road, N.E., Atlanta, Georgia 30324.

CLINICAL CENTER STUDY OF HEMOLYTIC ANEMIA

The cooperation of physicians is requested in the referral of patients for studies of idiopathic autoimmune hemolytic anemia being conducted by the National Institute of Allergy and Infectious Diseases at the Clinical Center, National Institutes of Health, Bethesda, Maryland.

Referrals of patients with Coombs' positive idiopathic autoimmune hemolytic anemia are needed. Also, selected patients with secondary types of autoimmune hemolytic anemia, especially of the cold antibody type, will be accepted. Preference will be given to patients who have not received previous treatment.

Studies will be performed to determine the type of antibodies involved and the role of complement in hemolysis. Following this, patients in need of therapy will be treated, and experimental drugs may be used. All patients will be carefully followed during the course of the study. On completion of their studies, patients will be returned to the care of the referring physician who will receive a summary of findings.

Physicians interested in having their patients considered for admission to these studies may write or telephone: Michael M. Frank, M.D., or John S. Sergeant, M.D., Clinical Center, Room 11-N-104, National Institutes of Health, Bethesda, Maryland 20014. Telephone: 496-4964 (Area Code 301).

HIGHLIGHTS OF THE MAG COUNCIL MEETING, JUNE 17, 1969

This summary is being sent to you so that MAG Officers and Councilors may be advised of the actions of the Council between meetings of the Council. It covers only major actions and is not intended as a detailed report in lieu of meeting minutes.

Voted to authorize reimbursement of expenses of the Immediate Past President to the 1969 Annual and Clinical Meetings of the AMA.

Approved the Executive Committee's appointment of 1969-1970 MAG Committees.

Received for future further action those matters referred to the Council by the 1969 House of Delegates.

Endorsed the new Code of Cooperation Between Medicine and Law and directed the staff to secure bids for printing and distributing the code either in the Year-book or in a separate pamphlet.

Heard a report that punitive or exemplary damage awards are not clear in the Georgia Code but that the St. Paul Company had determined that such damages would be covered under their policies when the occurrence resulted from professional conduct.

Voted to forward to the Board of Health the recommendation of the Hospital Activities Committee that Kidney Dialysis should be included in established programs of medical care.

Received for information a report from the Liaison Committee with the Board of Medical Examiners that indicated agreement is being reached with the Georgia Osteopathic Association and the Board of Medical Examiners on amendments to the Composite Board Bill.

Endorsed the recommendations of the Executive Committee that MAG Alternate Delegate and Executive Committee member F. W. Dowda occupy the AMA Delegate seat of J. W. Chambers, and that First Vice President Ronald Galloway occupy the AMA Alternate Delegate seat of F. W. Dowda. Also, approved the Executive Committee recommendation that the Delegation determine its own internal policies including determination of Delegation Chairman.

Appointed a Committee of John Rhodes Haverty, Chairman, Ronald Galloway, and Braswell Collins to investigate arrangements for an out-of-state meeting of Council in March, 1970, and report to the September Council meeting.

Heard a report that a Metropolitan Atlanta Council of Medical Societies had been formed with J. Frank Walker as Chairman, with its primary purpose the promotion of Areawide Health Planning.

Learned that the Georgia State Medical Association has discussed establishing joint Liaison Committee with MAG.

Noted its next meeting would be held September 20-21, 1969 at the Cloister, Sea Island.

HIGHLIGHTS OF THE MAG EXECUTIVE COMMITTEE OF COUNCIL MEETING, JUNE 17, 1969

This summary is being sent to you so that MAG Officers and Councilors may be advised of the actions of the Executive Committee between meetings of Council. It covers only major actions and is not intended as a detailed report in lieu of meeting minutes.

Appointed all 1969-70 MAG Committees.

Voted to recommend to Council that the House of Delegates action be endorsed referring the matter of Hospital Emergency Room Staffing to the Committee on Separate Billing.

Noted with regret the possibility of Delegate J. W. Chambers' not being able to attend the July AMA meeting and voted to recommend to the Council (1) that the AMA Delegation be allowed to determine its own internal policies and (2) that Alternate Delegate and Executive Committee member F. W. Dowda as-

sume Dr. Chambers' seat in the AMA House at the July meeting.

Received for future further action those matters referred to the Executive Committee by the 1969 House of Delegates.

Directed the Executive Secretary to prepare a staff study on MAG personnel.

Voted to recommend to the Council that it approve the principle of holding the March 1970 meeting of Council outside the state and to appoint a committee to study and report back to Council the possible alternative arrangements.

Decided to seek legal advice on the liability to hospitals and physicians in the use of externs to treat patients.

Set its next meeting to be held in the Georgia Suite of the Americana Hotel, New York, immediately following adjournment of the opening session of the AMA House of Delegates, Sunday, July 13, 1969.

GEORGIA LEADS THE NATION IN AMA/AMPAC WORKSHOP PARTICIPATION

TWENTY-TWO GEORGIA PHYSICIANS and their wives, comprising the largest delegation from any State in the Union, attended the AMA/AMPAC Public Affairs Conference on May 16-18, in Washington, D.C.

The Public Affairs Conference, successor to the annual Washington Workshop of the American Medical Political Action Committee, was highlighted by presentations from leading political personalities in Washington and medical spokesmen from throughout the country.

The primary objective of the Workshop has always been twofold: first, to motivate physician concern for political matters that bear directly on the continued progress of the medical profession; and secondly, to demonstrate in practical fashion proven techniques that will produce winners in political contests, the outcome of which is deemed significant to the profession. The 1969 Workshop accomplished these objectives.

In addition to the medical leaders on the program, the Workshop was treated to a "no holds barred" panel discussion by Senators Howard Baker of Tennessee and Tom Eagleton of Missouri, and Congressmen Omar Burleson of Texas and Don Riegle of Michigan. With candor and frequent intra-disagreement, this foursome probed the makings of a successful campaign and detailed many of the campaign subtleties lost on the unsuspecting and the politically unschooled.

Also featured on the program were four professional political campaign managers to supplement the remarks of the senators and congressmen and in general give a "pro's" view of how to win.

Adding zest to the Workshop were presentations by Congressman Gerald Ford, house minority leader, and Mr. Harry Dent, deputy counsel to President Nixon.



L. to R., front row: Luther Vinton, Mrs. Earnest C. Atkins, Dr. Atkins, Mrs. Vinton and Charles R. Andrews. Back row, John Kirk Train, Ollie O. McGahee, Neal Yeomans, T. A. Sappington and J. Frank Walker. Not pictured above, but also attending the Workshop were: Dr. and Mrs. Carson Burgstiner, Dr. and Mrs. Joseph A. Mulherin, Mrs. Train, Dr. and Mrs. Dan Bateman, Dr. and Mrs. John Meier, Herbert S. Alden, Mr. John Kiser and Mrs. James M. Moffett.

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THE MONTH IN WASHINGTON

The American Medical Association has offered to cooperate in a Senate investigation of large medicare and medicaid payments to physicians and other health practitioners.

The offer followed a Senate speech by Sen. John J. Williams (R., Del.), in which he reported that the staff of the Senate Finance Committee had found that several thousand doctors, dentists and others had received \$25,000 or more for their services under the two government programs in 1968.

In a second Senate speech, Williams expressed appreciation for the AMA offer to cooperate.

Appreciates Support

"This is the type of cooperation we need, and I appreciate this support from the American Medical Association," Williams told the Senate. "I sincerely hope that we shall have similar pledges of support from representatives of the other groups affected.

"I can assure each of these groups that our study will not result in a blanket indictment against any segment of the industry involved. We fully recognize that the overwhelming percentage of those who are in any way connected or working with this program are trying to do a good job; however, when instances of exploitation or excessive charges are discovered they must be exposed and properly dealt with."

Williams, who has announced he will not seek reelection next year, is a member of the Senate Finance Committee which is making an extensive study of the operation of medicaid and medicare.

Investigation Results

Williams said that, although a staff report would not be ready until later this summer, the committee's investigation already had shown:

"First, in 1968 the medicare program paid \$25,000 or more to each of at least 5,000 physicians.

"Second, thousands of health practitioners—doctors, dentists, optometrists, and others—were each paid \$25,000 or more under the welfare health care programs in 1968. . . . A surprising note is the large number of dentists appearing on the lists from welfare agencies. . . .

"Data has also been gathered and detailed tables prepared comparing the average medicare payments for the most common surgical procedures for older people with the maximum payments allowed under the most widely held Blue Shield contract in the same geographical area.

Startling Results

"The results are startling. Medicare's average payments run as much as two to four times as high as Blue Shield maximums. For example, in two areas of the country medicare's average payment for a cataract operation is more than four times as much as the Blue Shield allowance. These are not isolated cases. There is a pronounced pattern of inflated payments by medicare.

"The report to the committee will include pinpointing the causes underlying these extremely generous handouts of public funds.

"Another unusual situation has occurred in Social Security's pressing carriers to pay for so-called supervisory services rendered by a teaching physician even though the actual care is provided by an intern or resident. Before medicare virtually no insurer paid for such services. . . .

Further Investigation

"The investigation has expanded the evaluation of carrier and intermediary performance to determine whether the Government is getting what it is certainly paying for and the extent to which intermediaries and carriers are carrying out specific functions assigned to them by the medicare statute.

"Thus far a wide variance and level of performance has been observed. . . .

"The law requires intermediaries and carriers to exercise effective controls on utilization of services. . . .

"Yet some carriers and intermediaries appear virtually to ignore performance of this vital function while others seem to be doing a reasonably effective job."

AMA Statement

Following Williams' first speech, the AMA issued a statement saying that it shared with the Senator a concern over the rising costs of medicare and medicaid. The Association offered to cooperate with the Senate Finance Committee or any other congressional committee studying the problem of rising health care costs. The AMA earlier had made the same offer to Health, Education and Welfare Secretary Robert H. Finch.

The AMA statement said:

"For some time the AMA has been giving national leadership in coordinating the efforts of state and county medical societies in the establishment and effective functioning of local review and utilization committees checking on the health care services rendered under the medicare and medicaid programs. Close liaison also has been established between carriers and many medical societies in reviewing disbursements under the government programs.

Investigation Indications

"All investigations so far have indicated that an overwhelming majority of physicians participating in medicare and medicaid are charging reasonable fees. The charges of only about two per cent of the physicians receiving payments from the programs have been challenged. Of course, the AMA favors appropriate action in any of the cases where physicians are found to receive improper payments. Last June, the AMA Board of Trustees urged all state and local medical societies 'to act swiftly and firmly in all instances of known exploitation, and excessive charges for health care that may occur in their jurisdiction.' In 1967, the AMA said 'any reports of abuses by physicians or by

any other health care program should be thoroughly and promptly investigated and action taken where indicated.' Several medical societies have expelled members where it has been proved that a physician's charges were excessive or he in some other way exploited the program.

Physician Responsibility

"The AMA, through its publications and speeches by its officials, has been emphasizing to physicians the responsibility they have to hold down the health care costs of their patients both under and outside government programs. In an April 17 letter to Finch, Dr. Wilbur said the AMA 'is eager to make available to your office the composite experience and judgment of the nation's physicians, who are the principal providers of health care to all the people.'

" 'The knowledge and judgment of the nation's physicians—as well as of the prepayment plans, health insurance industry, hospitals, the allied health professions, the actuaries and others—must be enlisted in your battle against the health-care portion of the inflation problem,' Dr. Wilbur said.

Extension Passed

The House passed and sent to the Senate a three-year \$937 million extension of the Hill-Burton Act under which the federal government has helped finance construction of hospitals and nursing homes with 425,000 beds.

Members approved the measure on a 351 to 0 roll call after turning down a series of amendments designed to channel the matching hospital grants more into big cities than urban areas and into modernization rather than new hospital construction.

In addition to extending existing aid, the bill provides new loan guarantees, as requested by the Nixon Administration, and interest subsidies, which the Administration opposed.

The bill as passed authorizes appropriations (over three years) up to \$405 million for hospital construction; \$165 million for modernization; and \$300 million in guaranteed loans, toward which the government would contribute up to \$37 million in three per cent interest subsidies. In addition, grants up to \$30 million could be made for emergency room modernization.

Urged Approval

The American Medical Association urged that Congress approve full appropriations for medical education programs.

Dr. C. H. William Ruhe, director of the AMA's Division of Medical Education, testified before a House appropriations subcommittee that the nation's urgent need for more physicians could "only be met effectively by a major increase in the capacity of American medical schools to educate more physicians.

"It is therefore appropriate to emphasize again that full funding in the amounts authorized by the Health

Manpower Act of 1968 is necessary to permit the construction of new and expanded facilities before major enrollment increases will be feasible," Dr. Ruhe said.

In a letter to the House Public Health and Welfare Subcommittee, the AMA also supported extension of the Medical Library Assistance Act. Dr. Ernest B. Howard, AMA executive vice-president, said that "we cannot exaggerate the importance to the health professions and the public they serve" of the many beneficial services supported through the programs.

Council Attacks Pollution

President Nixon created the cabinet-level Environmental Quality Council to begin a major attack on pollution of the environment. He also named a companion 15-member Citizens' Advisory Committee on the recommendations of Lee A. Dubridge, Ph.D., his chief science adviser.

The President said the council, serving as an advisory board on a par with the National Security Council and the Urban Affairs Council, "will provide the focal point for this Administration's efforts to protect all of our natural resources."

Dubridge said "the problem is how we can make maximum use of our environment . . . without despoiling it." He said the council would move promptly on the problems of disposal of waste products—a key factor in deterioration of the environment.

President Heads Council

The President will head the council, which also will include the Vice-President and the Secretaries of Agriculture, Commerce, Health, Education and Welfare, Housing and Urban Development, Interior and Transportation.

Laurence S. Rockefeller, one of the nation's leading conservationists and a key figure in Lady Bird Johnson's National Beautification Campaign, will be chairman of the Citizens' Advisory Committee.

CHANGE IN MEDICARE PROCEDURE

A request for payment of Medicare benefits filed with a hospital by or on behalf of a hospitalized elderly patient will now be considered a written intent to claim both hospital insurance benefits under Medicare and cash social security benefits, Robert M. Ball, Commissioner of Social Security, announced today. This change became effective upon publication of a new regulation in the *Federal Register* of May 2.

Ball said that under the new procedure the request for payment of benefits filed with the hospital will serve to protect the person's social security and Medicare benefits during the period between the admission to the hospital and the taking of a formal application for benefits. He said that in the event that a patient died before he had an opportunity to file the claim, the application could be obtained from a member of the patient's family, a representative of his estate, or even the hospital itself.

HOSPITAL AND COMMUNITY DISASTER PLANNING MEETINGS

A series of four institutes designed to improve the effectiveness of disaster plans through coordination of professional efforts and citizen cooperation have recently been presented by the Georgia Hospital Association in cooperation with the Georgia Department of Public Health, the Medical Association of Georgia, and the United States Public Health Service.

The last of the series was held June 13 at Grady Memorial Hospital in Atlanta. Others were held February 14 at Phoebe Putney Memorial Hospital in Albany, April 25 at The Macon Hospital, and May 16 in Savannah at the Memorial Medical Center.

Duane F. Houtz, administrator at the Baptist Medical Center, Birmingham, Ala., showed slides of that hospital's emergency plan system. A plan detailing each person's responsibility and position during an emergency was developed and presented to the hospital staff and employees. Finally, drills were planned in cooperation with other agencies throughout the city.

Packaged Disaster Hospitals

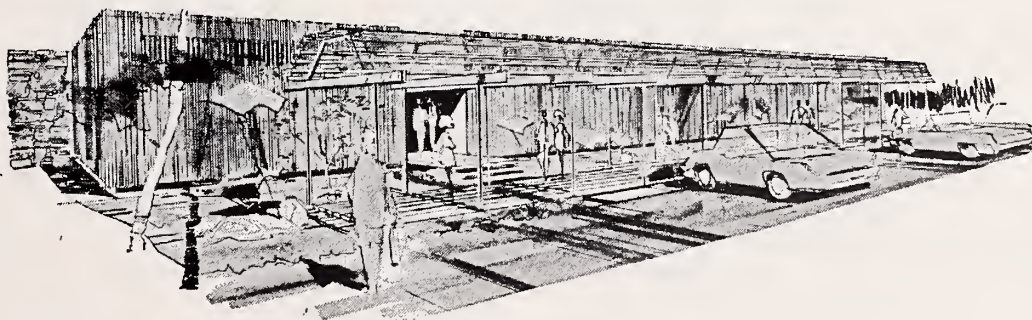
Charles W. Darden, Georgia Department of Public

Health, covered the subject of Packaged Disaster Hospitals and Hospital Reserve Disaster Inventories.

Packaged Disaster Hospitals are fully equipped 200-bed hospitals packed in boxes and stored throughout the United States. Hospital Reserve Disaster Inventory units are 30-day backup stocks of medicines and supplies which are being placed on the shelves of the nation's hospitals.

A comprehensive training program is available for hospital authorities to use in training their staffs to assemble and operate a packaged disaster hospital. The program includes a 16-mm color film, "Hospitals for Disaster," and a special Packaged Disaster Hospital Training Kit. The 27½ minute film shows a Packaged Disaster Hospital being set up and provides a general explanation of the program. These training aids are available through the State Health Department.

A local panel with representatives of civil defense, police, fire, city officials, schools and public health departments discussed local conditions of emergency preparedness and what could be done to improve them.



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AMA OFFERS GUIDELINES FOR SEX EDUCATION

Much of the current controversy in sex education could be eliminated if practical guidelines are followed, the American Medical Association said recently.

In making this observation, AMA reiterated its long-time stand in support of sex education for children and youth. A basic concept advocated by AMA is that, in schools, sex education should not be a separate course, project, or program. Rather, it should be an integral, important aspect of the overall health education program.

Responsibility for Education

Basic responsibility for sex education belongs to the home, AMA emphasizes in its guiding principles. But church, school, and some other community agencies have a supplementary role.

Those planning sex education in the schools should involve as many representative segments of the community as possible in planning and carrying out the effort, AMA says, adding:

"Persons involved in supporting efforts of the home through sex education in churches, schools, and other appropriate agencies must be exemplary individuals who are carefully selected and properly prepared. . . ."

Materials used in such instruction, AMA further

notes, must be carefully selected for the institution and child, general and educational suitability, physiological and psychological accuracy and appropriateness, and community acceptance in terms of local conditions, customs, and traditions.

Need for Counseling

Physicians, AMA says, are increasingly aware of the need for counseling in sex education and can contribute significantly to education of patients in this area.

The 217,000-physician AMA has a variety of programs in this area. More than a million copies of AMA's booklets on sex education have been distributed to date—at cost. The subject is discussed in AMA publications and at its conferences. (Human sexuality is a scheduled discussion topic for AMA's huge 118th Annual Convention in New York, July 13-17.)

Further, AMA has urged more training in medical schools and postgraduate education programs to prepare physicians for the sex education and counseling which are asked of them. And it encourages state and local medical societies to assist in communities' planning of family life and sex education as an integral part of health education.

GOVERNOR APPOINTS NEW HEALTH PLANNING ADVISERS

Gov. Lester Maddox has appointed seven new members, including the mayor of Gainesville, to the State Comprehensive Health Planning Advisory Council.

Also appointed to the 25-member group, which was formed in 1967 to give the public a voice in planning to meet Georgia's health needs, were four state businessmen, a Macon banker, and a Savannah woman active as a volunteer in health programs.

The new council members, appointed to serve three-year terms, are John Cromartie, mayor of Gainesville; A. E. Burell, a Smyrna businessman; Harold Lummus, a businessman and chairman of the board of the Columbus Medical Center; R. L. Tindol, Jr., an Atlanta businessman; Ernest Napier, a Moultrie businessman; J. V. Skinner, a Macon banker, and Mrs. Hunter M. Clay, Savannah.

All of the newly appointed members are so-called "consumers" or non-health professionals. The federal legislation that authorized formation of comprehensive health planning advisory councils in each state speci-

fies that more than half the members be consumers, in order to gain a broader consensus in long-range planning in the areas of personal health services, facilities, manpower and environmental health.

The council serves as adviser of the State Health Department's Office of Comprehensive Health planning in long-range planning for distribution of health services, manpower and facilities. The council is currently involved in developing data in order to determine priorities in developing future health services. The results of the group's planning activities are also available to other health-related agencies in Georgia.

Thomas J. Anderson, M.D., of Atlanta is chairman of the council, which also includes Mrs. J. Mac Barber, Athens; J. Gordon Barrow, M.D., director of the Georgia Regional Medical Program; Louis Brown, M.D., an Atlanta physician; Norman Burkett, administrator of Hamilton Memorial Hospital in Dalton, and William Burson, director, State Department of Family and Children Services.

REPORT FROM THIRD NATIONAL CONGRESS ON SOCIO-ECONOMICS OF HEALTH CARE

American Medical Association President Dwight L. Wilbur, M.D., told the opening session of the Third National Congress on Socio-Economics that the future of organized medicine depends on how well it presents its case to the American public. In his opening remarks to the congress, held in Chicago, Dr. Wilbur identified some of the problems and needs of the profession. Among them, he said, is a need to determine how much poor health is due to lack of patient care and how much to "historical lack of their environment," how much from non-availability of physicians and how much improving public transportation will help the situation.

Michael J. Halberstam, M.D., addressing the Congress said that too many social planners are misinformed and are creating myths about American medicine which may lead to change, but hardly for the better. He went on to say that "unless trust and respect are established between doctors and planners and unless honest research is conducted, rather than preordained self-fulfilling studies, then medicine will not be reformed." If progress is to come, he said it is important for physicians and planners to note and realize that medicine can be improved.

Increasing Inflation

According to W. Fred Mangank, vice-president and secretary of Black and Skaggs Associates, Battle Creek, Mich., at the 1968 rate of inflation a physician must increase his net earnings by 10 per cent a year just to break even. This fact, he said, does not take into account the progressive tax rates of many States and local municipalities or increasing local taxes. Six major problems were listed that face the practitioner. They are the demands for higher productivity; the boom in malpractice cases, necessitating that the physician keep more detailed, and costly records; increased paper work due to the increased amount of business; the necessity to stay up with the growing volume of Medicare and Medicaid claim forms or face loss of income; the necessity for additional office help to keep up with the increased workload; and "increased governmental controls."

A Rye, New York physician predicted government-backed medical care and social programs will continue to expand during the 1970's and the public, as usual, will foot the bill.

Program Disappearance

William C. Felch, M.D., a trustee of the American Society of Internal Medicine, also predicted that Medicaid programs as we know them may disappear during the next decade, and that the three methods of paying for health care through personal resources, health insurance plans, and government funds will be about equally divided. He noted that personal out-of-

pocket expenses for health care amounted to about 40 per cent of the health care bill in 1967.

In dollar expenditures Dr. Felch said, "Health care will be a \$65 billion-a-year industry by 1970 and \$100 billion near 1976. Per capita expenditures will be over \$200 in 1967 and over \$400 by the end of the 70's. In short, health care will pass agriculture and transportation to become the biggest industry in the country."

Driving Force

Donald C. Harrington, M.D., president of the San Joaquin Foundation for Medical Care, Stockton, California, reported that the county medical society must become the driving force behind organized medicine or physicians will have to abrogate leadership to civic or governmental bodies. Further, he said, traditional concepts of fee for service as usual, customary and reasonable rates cannot survive without adequate controls of quality and overutilization by "peer review" at the local level.

Ross V. Taylor, M.D., said the physician as a solo practitioner per se no longer really exists. "The individual physician is an indispensable part of any health care system," he continued. "Economics will group physicians together for the sharing of expensive equipment, even though they may remain independent in practice without group or partnership affiliations."

No Immediate Threat

Dr. Taylor saw no immediate threat of the socialization of medicine, but stated, "it would seem likely that for some period of time at least there will be a mixture of governmental and voluntary health insurance financing of health care."

According to Dr. Taylor the future of American medicine revolves around two issues. First, "every individual has a right to medical care. Secondly, medicine will continue to have the responsibility that the profession render the best service and highest quality care while continuing to advance medical knowledge."

Medical organizations as they exist today are not capable of meeting the social and economic problems of medicine, Richard S. Wilbur, M.D., told the National Congress.

Meet Challenges

Medical organizations "were formed to meet the challenges of the increasing complexity of scientific medicine, not to deal with social problems. The physician should neither withdraw from his organizations, thus creating a vacuum, nor should he react and oppose all change," the chairman of the Council of the California Medical Association asserted.

"The proper course of organized medicine is to show leadership and responsibility," Dr. Wilbur stated. "The physicians' post-graduate scientific and clinical

REPORT / Continued

knowledge must be paralleled with socio-economic knowledge.

"Leadership and responsibility include involvement in organized medicine," he said. "Beyond what the physician may do as an individual participant, what

he must do is to be certain that he has good representation within organized medicine. The busy practitioner cannot handle all of this himself. However, it is best that these representatives be men who are working doctors. Answers which appeal to theorists in ivory towers and which read well on paper often do not benefit living, breathing patients."

OB-GYN SEMINAR TO MEET JULY 28-AUGUST 1

The 15th Annual Southern Obstetric and Gynecologic Seminar, Inc. will be held this year at the Grove Park Inn in Asheville, N.C., Monday, July 28 through Friday, August 1. A wide variety of obstetric and gynecologic subjects will be covered, including a comprehensive review of gynecologic pathology by Dr. Cary Dougherty of LSU.

The seminar is designed for informal teaching and includes numerous panels and open discussions. Sessions will be held in the mornings, with the afternoons free for recreation. The active faculty this year will be Drs. Bayard Carter and Art Christakos of Duke University; Dr. Robert Ross, President-elect of the Amer-

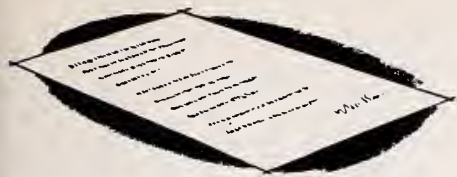
ican College of Obstetrics and Gynecology; Drs. Cary Dougherty, Abe Mickal and George T. Schneider of LSU; Drs. Robert Franklin, Raymond Kaufman and Herman Gardner, of Baylor University; Dr. Erskine Carmichael of the University of Alabama; Dr. Robert Greenblatt, of Augusta, Ga.; Dr. Stewart Fish, of the University of Tennessee, and Dr. Charles Hendricks of the University of North Carolina.

Registration for the course, including a cocktail party and banquet, is \$50. For further information and registration, contact Dr. George T. Schneider, Ochsner Clinic, 1514 Jefferson Highway, New Orleans, La. 70121.

CORRECTION: The caption for the picture on page 231 in the June issue of the *Journal* should have read as follows: Dwight L. Wilbur (center), president of AMA, chats with J. Frank Walker, president of Fulton County Medical Society and John Kirk Train, MAG president.

CORRECTION: The caption for the picture on page 255 in the June issue of the *Journal* should have read as follows: John T. Mauldin, M.D. of Atlanta; J. S. Wilson, M.D. of Atlanta, and J. Frank Walker, M.D. of Atlanta relax for a few moments.

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ABSTRACTS BY GEORGIA AUTHORS

Bush, Chas. A., M.D., Grady Mem. Hosp., 80 Butler St., S.E., Atlanta, Ga. 30303, "Study of Pressures on Skin Under Ischial Tuberosities and Thighs During Sitting," Arch. Phys. Med. and Rehab. 50:207-213(April) 1969.

The measurement of body contact pressure sustained by the ischial tuberosities while sitting was measured by having normal subjects sit in a wheelchair fitted with seats of three different lengths. The changes in pressure were recorded with the feet in three different positions: with the feet hanging free; with the feet supported; and with the legs extended and supported at the calves. Simultaneous recordings of thigh contact pressure were also taken. A portable pressure sensitive system was used which consisted of a transducer and a readout component.

Support of the feet resulted in significantly higher body contact pressures under the ischial tuberosities. Pressures in excess of 30 pounds per square inch were often recorded. Pressures recorded with the legs in the other two positions indicated that the ischial tuberosity pressures were not significantly different whether the legs were allowed to hang free or were extended at the knees with support at the calves. Thigh pressures were significantly higher when the legs were allowed to hang free than when the legs were in the other positions.

Rooker, Donald W., M.D., and Jackson, Richard T., Ph.D., Joseph B. Whitehead Dept. of Surgery, Division of Otolaryngology, Emory U. School of Med., Atlanta, Ga. 30333, "The Effects of Certain Drugs, Cervical Sympathetic Stimulation and Section on Nasal Potency," Annals of Otolaryngology, Rhinology, and Laryngology 78:403-414(May) 1969.

Nasal congestion is a very common and poorly understood clinical problem. Investigation of nervous and pharmacological control of the nasal blood vessels, the source of nasal congestion, is in a developing state.

Our studies re-affirm that the cervical sympathetics innervate the blood vessels lining the nasal passage. Cervical sympathetic stimulation and sympathetic drugs produce vasoconstriction in a predictable manner.

There is a "normal" sympathetic tone in the nose keeping the vessels partially constricted and the airway open. Sympathetic blockade or cervical sympathetic interruption eliminates this "tone" causing nasal obstruction.

Kilpatrick, Z. M., M.D., and Katz, J., M.D., Med. College of Ga., Augusta, "Occult Celiac Disease as a Cause of Iron Deficiency Anemia," JAMA 208:999-1001(May) 1969.

When celiac disease is mild, intestinal absorptive function may be impaired without gastrointestinal symptoms and without abnormalities of the usual tests of absorption. Thus, celiac disease may be the cause of iron deficiency in patients who do not have clinically apparent malabsorption. We have studied two women with chronic iron deficiency anemia who did not respond to oral iron therapy and who had no abnormal blood loss. They had no gastrointestinal symptoms, and, in one patient, serum carotene levels and d-xylose excretion were normal. Although the clinical and laboratory evidence for celiac disease was scant, the diagnosis was made by the demonstration of total villous atrophy on small bowel biopsy, increased amounts of fecal fat excretion, and a favorable response to a gluten free diet. The anemia disappeared on treatment with dietary gluten restriction and oral iron.

Although the intestinal defect related to gluten sensitivity usually affects the absorption of many nutrients, a seemingly selective malabsorption of iron was notable in these patients. Iron is absorbed mainly in the proximal small bowel, which is the portion of the gut most injured in celiac disease. The lesser involvement of the more distal bowel allowed normal absorption of other substances and was responsible for the paucity of clinical and laboratory evidence of malabsorption.

Since celiac disease usually responds to dietary therapy, this disorder should be suspected in patients with iron deficiency anemia who are refractory to oral iron. Tests of intestinal absorption and small bowel biopsy are indicated in this clinical setting.

Jarrett, Wm. H., II, M.D., and Gutman, Froncie A., M.D., Dept. of Ophthalmology, Emory U. School of Med., 1365 Clifton Rd., Atlanta, Ga. 30322, "Ocular Complications of Infection in the Paranasal Sinuses," Arch. Ophthal. 81:683-688(May) 1969.

Seven cases of ocular complications arising from primary disease in the paranasal sinuses are presented and discussed. This type of disease has become a medical rarity due to widespread antibiotic usage, but when such cases do occur they present major diagnostic and therapeutic problems. Prompt recognition of the correct diagnosis is the keystone of proper therapy. Such cases are treated with massive doses of antibiotics and timely surgical drainage.

Blue, C. Milton, Ph.D., University of Ga., Athens, Ga., "PPVT Temporal Stability and Alternate Form Reliability with the Trainable Mentally Retarded," American J. of Mentally Retarded, 73:745-748(March) 1969.

An investigation of (1) one year temporal stability (Form A) and (2) alternate form reliability of the PPVT was conducted with 116 trainable retardates, CA 6-6 to 32-8. All Ss were enrolled in a community day school. Fifteen of the Ss were available for alternate form testing only.

A correlation matrix was prepared using Raw, IQ, and MA scores for the total group and for subgroups based on CA; 10 years, 10-14 years, and 14. IQ scores used were taken from the manual and included many derived by extrapolation.

Alternate form correlation coefficients ranged from a low of .77 for IQ scores at the youngest age level to a high of .92 for raw and MA scores for the total group.

Temporal stability coefficients ranged from a low of .75 for raw scores at the youngest level to a high of .93 for MA scores for the total group.

It was concluded that the PPVT demonstrated high reliability in both alternate form testing and one year interval test-retest (Form A) regardless of the form of scores employed or age groupings.

Cohen, Sheldon B., M.D., 401 Peachtree St., N.E., Atlanta 30308, "Hypnosis and Smoking," JAMA 208:335-337(April 14) 1969.

Hypnosis, because of its hypersuggestibility, has been advocated as treatment for those who desire to stop smoking. The literature abounds in fascinating, dramatic cures. With the exception of a single series of eight cases, there are no groups with any controls, adequate follow-up or which take into account possible therapist bias. The author has often been called upon to use hypnosis to help individuals stop smoking. Most who inquire appear to have superficial motivation and do not even make an appointment. Of 10 consecutive chronic, heavy smokers seen, most had serious organic disease, which included bronchiectasis, emphysema, pre-cancerous lesions of the vocal cords, and previous myocardial infarction. Nine of the 10 patients displayed conspicuous psychopathology; six had serious marital problems; five drank excessively; three had weight problems; some were depressed or phobic. Five patients were successfully hypnotized; four reduced the amount of smoking or stopped temporarily. Most of these people had

ABSTRACTS / Continued

few, if any, other source of satisfaction and pleasure in life besides smoking. Several patients developed disturbing emotional symptoms when they stopped smoking (e.g. gross anxiety, increased drinking, and outbursts of rage). The scientific basis for hypnosis as a smoking "cure" has yet to be established. Future studies may reveal individuals with particular personality patterns that may benefit significantly.

McClure, John N., Jr., M.D., and Skardasis, George M., M.D., Dept. of Surgery, Crawford Long Memorial Hospital, 35 Linden Ave., N.E., Atlanta, Ga., "Jejunal Diverticula," S. Med. J. 61:1369-1373(Dec.) 1968.

The charts of all patients admitted to the Crawford W. Long Memorial Hospital of Emory University with the diagnosis of jejunal diverticula during a recent 10-year-period were studied. Eighteen patients were found and serve as a basis for this report. Nine were males and nine females.

There were 17 in which the lesions were located only in the jejunum and two instances in which the diverticula were present in both jejunum and ileum. They occurred primarily in the middle and older age group of patients, with only one patient under the age of 40.

Usually the diagnosis was made by x-ray or at operation. The predominant

symptoms among patients were abdominal pain, nausea and vomiting, rectal bleeding, distension, weakness, flatulence and loss of weight.

Complications encountered among these patients included—hemorrhage 5, inflammation 5, perforation 4, macrocytic anemia 2, and obstruction 1.

In patients with mild symptoms or in poor risk patients medical treatment may be satisfactory. In patients with severe symptoms or complications operation is the treatment of choice.

In this series six patients were treated by resection of the involved segment of small bowel and end-to-end anastomosis without mortality, or significant postoperative complications.

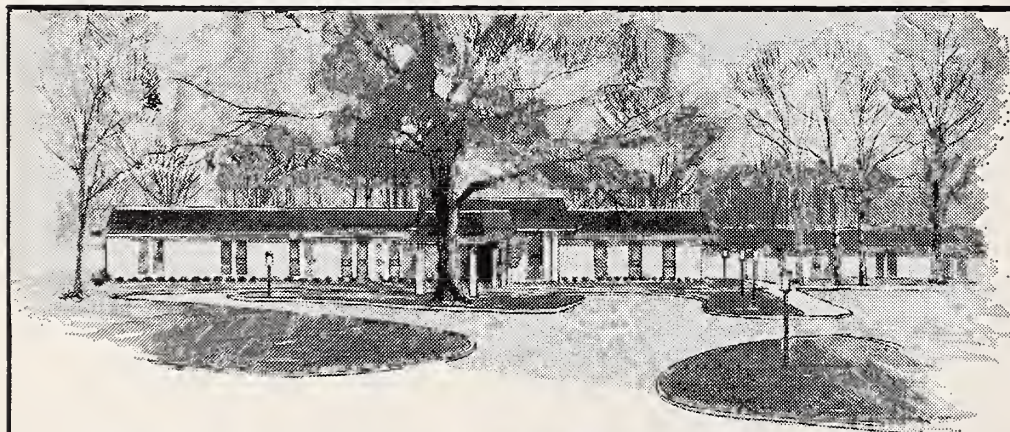
Stevens, Charles D. and Mosteller, Robert C., School of Med., Emory U., Atlanta, Ga. 30322, "Enhancement by Glucose of the Inhibition of an Ehrlich Ascites Tumor by Tetraazatricyclododecane," Cancer Research 29:1132-1136(May) 1969.

The survival of mice inoculated with Ehrlich ascites tumors was prolonged by the intraperitoneal injection on the following day of an isotonic solution of glucose (100 ml/kg) containing 1 to 2 millimoles of tetraazatricyclododecane per kg. of body weight. The addition of tetraazatricyclododecane to the solution of glucose increased the average length of survival (geometric mean) from 18.0 to 149 days. When isotonic galactose or sodium chloride was sub-

stituted for glucose, the addition of tetraazatricyclododecane increased the average survival from 19.4 to 71.4 days. The difference between the two increases in survival has a probability of 1 in 50 of being due to chance alone. Similar injections made subcutaneously were ineffective.

No complete remissions were seen and the incidence of partial and questionable remissions was the same with both drugs. To qualify for a partial remission it was required that a 50 per cent decrease in abnormal serum or urine protein of a 50 per cent decrease in area measurement of a tumor mass occur. Any lesser response was considered questionable. Immunoglobulin type as determined by immunoelectrophoresis, light chain type, and plasma cell morphology did not correlate with response to therapy. Toxicity was similar except for a higher incidence of thrombocytopenia in the melphalan treated group ($P = 0.04$). Median survival of all patients was 12.3 months in the group receiving cyclophosphamide and 15.5 months in the patients receiving melphalan, a statistically insignificant difference. Both drugs appear to be equally effective in the treatment of myeloma.

The incidence of remissions and lack of significant toxicity suggest that oral alkylating agents should be tried in any patient with generalized plasma cell myeloma. Choice of agent and dose regimen should depend on the preference of the physician.



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MEDICINE-RELIGION SYMPOSIUM SCHEDULED

A symposium on medicine and religion entitled "Dialogue and Dilemma," will be held at the University of North Carolina School of Medicine in Chapel Hill Monday and Tuesday, September 8 and 9, 1969. This will be the second program bringing clergymen and physicians together for joint discussion of problems of mutual concern, and is sponsored by the Committee on Medicine and Religion of the North Carolina State Medical Society, the School of Medicine and the Department of Medicine and Religion of the American Medical Association. The program

will include nationally known speakers, both physicians and clergymen, and will provide opportunity for informal discussions in small groups.

Interested clergymen and physicians are cordially invited, and it is particularly hoped to have "teams" of physicians and clergymen from the same community. Further information may be secured from:

Office of Continuation Education
U. N. C. School of Medicine
Chapel Hill, North Carolina 27514

PUBLISHED REPORTS BLAST CHIROPRACTIC

A special report to the U.S. House of Representatives by the Department of Health, Education and Welfare on the inclusion of "Independent Practitioners" in Medicare denounces chiropractic and raises serious questions regarding the educational qualifications of those cultists.

The report strongly recommends that chiropractors not be included in Medicare, and devotes 50 pages to

the chiropractic philosophy and the lack of scientific proof behind its basic tenants.

In another report, the National Council on Senior Citizens, an organization often at odds with the American medical profession, issued a devastating indictment of chiropractic in its January issue of the *Senior Citizens News*. The article entitled "Why Chiropractic Cult Cannot Provide Quality Health Care" is a brief but detailed exposé.

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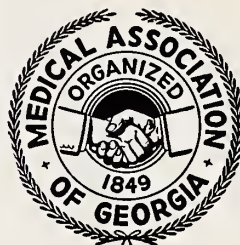
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THE

Journal

OF THE

MEDICAL ASSOCIATION OF GEORGIA



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MANUSCRIPTS—Articles are accepted for publication on the condition that they are contributed solely in this *Journal*. Manuscripts should be typewritten, double-spaced, and the *original and one copy should be submitted*. Receipt of manuscripts will be acknowledged and unused manuscripts returned. Used manuscripts will be returned only if requested.

STYLE—Ordinarily articles should not exceed 3,000 words. Only under exceptional circumstances will articles of over 4,000 words be published. Footnotes, bibliographies, and legends should be typed on separate sheets, double-spaced. Bibliographies should conform to the style of the Quarterly Cumulative Index published by the American Medical Association—i.e., name of author, title of article, name of periodicals (underlined) with volume, page, month, day of month if weekly, and the year. They should be listed in alphabetical order and numbered in sequence. Example: 1. Jones, S. R.: Spontaneous Epistaxis; *Arch. Int. Med.*, 36:434 (Dec.) 1946.

NEWS NOTES—District and county medical societies, Association members, and readers are invited to send in any news items of general concern to members of the Medical Association of Georgia.

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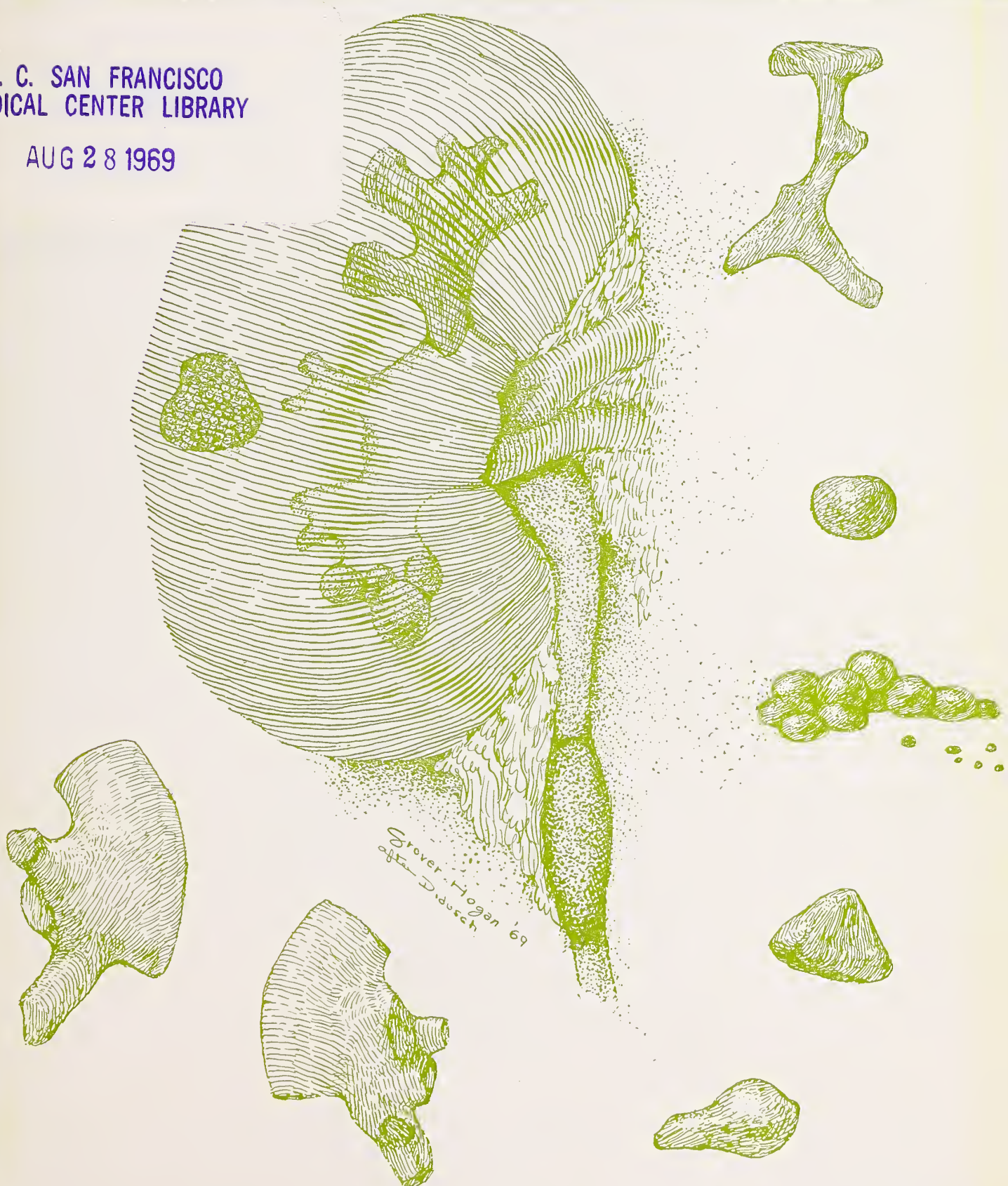
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*Special Address to the 115th Annual
Session of the Medical Association of
Georgia, Savannah Inn and Country
Club, Savannah, May 5, 1969.*

Special Article

Reorganization, Objectives and Changes in AMA

DWIGHT L. WILBUR, M.D., *President, American Medical Association*

THE AMERICAN MEDICAL ASSOCIATION is in an era of change.

It is a time not of ferment—but of reorganization, consolidation and realignment.

It is a time of studying the Association's personnel, programs, policies and priorities . . . to see what is being done that can be done better . . . and what is not being done that should be undertaken.

Changes are being made or possible changes are being studied in the organization and in the very objectives of the AMA.

This is a time for planning for the future.

Studies and recommendations have been made or are in the process of being made by outside management consultants . . . by the AMA's public relations counsel . . . by the Board of Trustees . . . by the newly appointed Committee on Health Care of the American People . . . by those who are forming the Advisory Committee on Medical Science . . . by the Association's own Committee on Planning and Development . . . and by the Ad Hoc Committee to Study the Modus Operandi of the Scientific Sections.

New Additions

A new Division of Public Affairs has been created . . . new directions for the Washington office have been proposed . . . and a new group has been formed in the office of the Executive Vice President to provide more complete staff services for AMA officers and trustees . . . and to strengthen liaison with

state and local medical societies as well as with other leaders and organizations of medicine.

There is a new director of the Communications Division.

And plans are being made to move the Institute for Biomedical Research to a location adjacent to the campus of the University of Chicago.

Let me begin with a review of the over-all objectives of the AMA.

Article Two of the AMA Constitution, adopted in 1847, contains this very broad statement:

"The objects of the Association are to promote the science and art of medicine and the betterment of public health."

Define Purposes

At the 21st Clinical Convention in November, 1967, the Board of Trustees recommended that the Association's purposes be more clearly defined so they would be understood better. The House of Delegates approved in principle a statement of "The Purposes and Responsibilities of the American Medical Association," with the understanding that they would be reviewed from time to time to assure that they stay up to date in light of changing social and political influences.

Here they are:

"It is the responsibility of the American Medical Association, as the representative of the American medical profession, to continue to foster the ad-

SPEECH / Continued

vancement of medical science and the health of the American people. Its continuing purposes are to meet this responsibility through the following means:

"1. By encouraging the further development of medical knowledge, skills, techniques and drugs; and by maintaining the highest standards of practice and health care.

"2. By creating incentives to attract increasing numbers of capable people into medicine and other health-care professions.

"3. By advancing and expanding the education of physicians and other groups in the health-care field.

"4. By motivating skilled physicians who have the art of teaching to apply themselves to developing new generations of excellent practitioners.

"5. By fostering programs that will encourage medical and health personnel to serve voluntarily in the areas of need for medical care.

"6. By developing techniques and practices that will moderate the costs of good medical and health care.

"7. By seeking out and fostering means of making all health-care facilities—physicians' offices, hospitals, laboratories, clinics and others—as efficient and economical as good medical practice and attention to human values will permit.

"8. By combining the utilization of the latest knowledge for prevention and treatment with the vital healing force of the physician's personal knowledge of and devotion to his patient.

"9. By maintaining the impetus of dedicated men and women in providing excellent health care by preserving the incentives and effectiveness of unshackled medical practice.

"10. By maintaining the highest level of ethics and professional standards among all members of the medical profession.

"11. By continuing to provide leadership and guidance to the medical profession of the world in meeting the health needs of changing populations."

Steps to Meet Objectives

Many steps are being taken to gear up the organization to meet those objectives. One of the most important was to have an outside firm of experts take a close look at the Association.

After approximately three months of studying the AMA, the management consultant firm of Cresap, McCormick and Paget turned over to the Board of Trustees in January of this year Phase I of its report.

The study included interviews with approximately 70 officers, trustees and staff members . . . with 15 officers of state and county medical societies . . . and

with 30 persons outside of the AMA, including former staff members, representatives of allied health organizations and physicians in education, research and private practice.

The surveyors also reviewed a host of documents relating to the functions, achievements and aspirations of the Association.

Phase I Study

It is not possible in a brief time to review the Phase I study in any depth. But perhaps this quotation from its introduction will give you some idea of the thinking of the consultants.

I quote from the Phase I report:

"The present ferment in health care, together with the increasing involvement of the federal government in planning and financing health care and research, as well as the increasing demands for quality care by the American public, indicate the need for an organization that will ensure the Association's position of leadership in meeting these needs now and in the foreseeable future . . . that will respond to change . . . and that will permit the effective utilization of available human, physical and financial resources.

"It is essential that the proposed organization provide an effective means of developing, adopting and implementing Association policies and programs in response to the requirements of today.

Provide Appropriate Services

"It also should provide appropriate administrative and support services so that the programs of the AMA can be developed and implemented expeditiously and at reasonable expense."

Many of the conclusions of the management consultants were stated as headings in the report—each one followed by discussion of the subject to fortify the consultants' point of view.

To capture the essence of that report, let me read to you several of those conclusions:

—The role and responsibilities of the Board of Trustees appear to be unclear.

—The number of councils and committees appears to be excessive.

—The present policy with respect to the term of office of the chairman of the Board may detract from continuity at the Board level.

—The role, authority and responsibilities of the chief administrative officer have not been clearly defined.

—The present internal organization structure for administering the affairs of the Association does not appear to be adequate for present or future requirements.

—There is no systematic personnel program for the professional staff.

—There is little evidence of sound program planning and allocation of resources in accordance with approved program priorities.

Growing Staff

—The administrative staff is growing, and the allocation of staff among divisions may not reflect program emphasis.

—The role, duties and responsibilities of the Board should be clarified.

—The Board should establish a management committee.

—Consideration should be given to enlarging membership of the Board and the terms of trustees should be extended one year.

—The role and responsibilities of the chairman of the Board and the president should be clarified.

A special committee of the Board is studying the conclusions and recommendations of Phase I and will report to the whole Board at its meeting in May.

Most Important Step

The most important step made so far in organizing or reorganizing the AMA staff to meet the heavy challenges of the future was the appointment of Ernest B. Howard, M.D., as executive vice president.

Bert Howard has been with the AMA for 21 years and was the unanimous choice of the Board of Trustees for the top staff job.

Approximately 25 men were considered for the job before Dr. Howard was chosen without a single dissenting vote.

It is difficult to know in what order to discuss the many changes that have been made . . . and that will be made . . . in the Association.

But let me move now to an area in which most physicians have a special interest—the area of public affairs.

Division of Public Affairs

As of September, 1968, the AMA established its Division of Public Affairs, amalgamating the field staffs of the AMA and AMPAC . . . assuming the functions of the former Division of Field Service . . . and taking on broader responsibilities in the public affairs area.

Joe D. Miller, former executive director of AMPAC, was named director of the new division. Before going to AMPAC, Miller had spent four years at the AMA, the last two in the field service division.

Public Affairs has been defined as a systematic effort to safeguard an organization's rights and, at the

same time, fulfill its responsibilities to the community . . . while encouraging its individual members to fulfill their responsibilities and protect their rights.

In summary, public affairs is a term used to describe almost every aspect of the relationship between government and a group.

Division's Responsibilities

The AMA Public Affairs Division is charged primarily with the AMA's governmental and association relationships. The division is responsible for helping our membership attain legislative objectives by working with Congress and governmental agencies.

It also is responsible for educating physicians and their wives for effective participation in politics and government . . . analyzing legislative proposals . . . and keeping state and county medical societies aware of political and governmental developments.

The division also provides a link between the AMA and the physician member through state and county societies. That liaison also is carried out for the benefit of other AMA divisions whose programs are carried to the field by the division's staff.

The staff also keeps the AMA in touch with the programs and the problems of state and county societies.

Enlists Support

Since many of the AMA's goals and special projects are far-reaching, the work of the staff often involves enlisting the support of local, regional or national organizations having a special interest in health and welfare needs, in order to encourage governmental action in the best interests of the public and the profession.

The division has four staff groups:

1. The central direction comes from the division office in Chicago. It is here that the division director and his department heads coordinate and control division operations and maintain liaison with the Washington office and all AMA divisions and departments.

2. The Legislative Department staffs the Council on Legislative Activities . . . studies, analyzes, interprets and reports on all congressional legislation pertaining to health and medical care . . . helps AMA officials prepare testimony and develop presentations for congressional hearings . . . and keeps members abreast of legislative developments.

It issues two publications: the monthly *Medical Legislative Digest* and the weekly *Legislative Roundup*.

3. The Department of Congressional Relations has four legislative representatives of the AMA stationed in Washington, D.C. Each one is assigned to

SPEECH / Continued

approximately one-fourth of the members of congress, including House and Senate. They provide information to the congressmen, and relay questions from them to the AMA.

4. The Department of Field Service has a man in each of 12 regional offices, each one serving an average of four states. These men work closely with state and county societies in a variety of public affairs programs and provide liaison with Chicago for coordination of other AMA activities.

Division Summary

To summarize, in setting up the Public Affairs Division, the Board of Trustees took action to group together all of the major departments and elements of the AMA with daily concern for contact with government.

The purpose in putting them into one management unit is to develop better coordination of all activities in Washington and in the field relating to AMA's relationship with the government.

Talking about public affairs naturally enough leads to the subject of the AMA's Washington office.

Structure Under Review

At the present time, the entire structure of that office is under review by a committee of the Board of Trustees. Action is expected at the Board's meeting in May.

There has been a great deal of discussion about the office . . . much research has been done . . . and numerous alternatives have been proposed which the Board committee is now considering.

During this period, the Washington office is functioning without an over-all director. However, Mr. Darrell Coover is director of the Department of Governmental Relations.

Organizational Growth

The way in which the Washington office is now organized has grown through the years with little central direction and a lack of unified objectives.

In discussions about the office, it has been suggested that it be consolidated so that the director of it would be totally responsible for the running of the office and for the functioning of all of its personnel.

The director, of course, would be responsible to the AMA in Chicago.

However, it is not possible to say at this time exactly what the Board will decide to do with respect to the office.

Physician Interest

I find that physicians also are very much interested in the Institute of Biomedical Research, since

it is a research facility they support with their gifts.

At the Clinical Convention in November, 1967, a special report from the AMA-ERF announced that the Board of Directors of the AMA-ERF had "voted to endorse in principle the relocation of the Institute of Biomedical Research on, or contiguous to, the University of Chicago campus. . . ."

The House approved the action of the AMA-ERF Board and endorsed in principle the relocation of the institute.

New Director

And, coincidental with the opening day of the Clinical Convention on December 1, 1968, a new director of the institute began what we know will be a distinguished tenure.

He is George W. Beadle, Ph.D., president emeritus of the University of Chicago and a Nobel Prize winner in 1958 for research in genetics.

Dr. Beadle announced in March that preliminary plans are complete for the institute building that is to be constructed adjacent to the University of Chicago campus. Working drawings are being prepared by architects and will be submitted to the AMA Board of Trustees for approval.

Dr. Beadle estimated that construction will be completed in about three years.

Research Continues

Meanwhile, research continues in laboratories in the AMA headquarters building in Chicago. Programs have been planned around the objectives of providing new and more effective diagnostic and therapeutic methods to help medicine's understanding of the causes and mechanisms of disease.

It has been four years since the institute began active research, and it now has six departments. They deal in studies of neurobiology . . . molecular biophysics . . . experimental medical ecology . . . regulatory biology . . . virology and immunology . . . and animal research.

Important Contribution

Although there are many other laboratories conducting biomedical research, the AMA institute contributes importantly to the diversity and competition that have given the United States a commanding position in biological science and technology.

Dr. Beadle recently commented that, "It is important that the more than 200,000 members of the AMA feel a sense of involvement in the creation of knowledge that underlies all medical practices."

In a report on institute activities, the director emphasized that programs and projects—and the construction of the new building—are being done with private funds. None of the projects gets any federal

money, although many other institutions accept matching funds through government educational programs.

International Symposium

The AMA institute sponsored its first international symposium March 24 through March 28 in Chicago. More than 40 scientists from areas throughout the world participated in the program, which was on neurobiology—the study of the nervous system as it occurs in various animals.

Since the future of the AMA, and the future of medicine as a whole, depends to a large extent on planning, one of the most important groups in the Association probably is the Committee on Planning and Development.

Adopted Report

At its Annual Convention in 1966, the House of Delegates adopted a report from the Board of Trustees, announcing the appointment of such a committee to study planning and development techniques within the Association.

The charge to the committee was that it do three things:

“a. Study and make recommendations concerning the long-range objectives of the Association and the resources, programs and organizational structure by which the Association attempts to reach them.

“b. Serve as a focal point for the planning activities of the Association and stimulate and coordinate planning activities throughout the organization. (And . . .)

“c. Study, or cause to be studied, medicine and the environment in which the Association must function and transmit the conclusions of these studies in the form of recommendations to the Board of Trustees for distribution to appropriate decision-making centers throughout the Association, particularly the House of Delegates.”

Face Realities

The report of the Board in 1966 pointed out that the committee “will be required to face social, economic and political realities which may differ from their previously held beliefs and aspirations, and within this context of reality it must spearhead the planning efforts of the Association with complete objectivity and always in the best interest of the public and of the profession as a whole.”

That committee on planning and development now has finished its assignment. Its chairman, Dr. Himmler, will appear before the Board of Trustees at its meeting this month to present his committee's report. The committee has reviewed the activities of the Association . . . has studied major problem

areas under consideration . . . and has made specific recommendations for the future.

The report is nearly 100 pages long, and it is not possible to say now whether the entire report or a summary of it will become a report to the House of Delegates.

Reviewed by Committee

I'd like to add that the committee reviewed Phase I of the management study by the firm of Cresap, McCormick and Paget. But its report does not comment on that study, since the Board of Trustees has appointed a committee of its own members to review and report to the Board on Phase I.

I would like to give you just one example to illustrate the flavor of the Planning and Development Committee's report. It states as an objective, “That the AMA endeavor by all appropriate means to make health services of high quality available to all individuals in a dignified and acceptable manner, regardless of their social class . . . ethnic origin . . . ability to pay for services . . . or the source of the payment.”

The committee then points out that, “The American Medical Association has the duty to guide and assist the medical profession in attaining this objective.”

Important as it is for physicians to look at their own Association, it is perhaps equally or more important that knowledgeable people outside of medicine also look at it.

Established Committee

In the latter part of 1968, the Board of Trustees established the AMA Advisory Committee on Health Care of the American People. At present, it consists of eight prominent laymen, each distinguished in his own field. More will be added later.

The purpose of creating the committee was to give the AMA access to the viewpoints of persons in professions, business, labor, religion, education and other activities outside of the medical world and related to society as a whole.

It was the Board's feeling that a group such as this could take a look at medicine and at the relationships between the AMA and society and indicate some solutions to problems that exist.

Helpful Suggestions

The Board did not specify a charge for the committee. Instead, it issued, as it were, a blank check in the hope that the committee might give the Board and our profession some helpful suggestions, directly or indirectly, with respect to health problems in this nation.

To give you some idea of the scope of the com-

SPEECH / Continued

mittee's areas of deliberation, it was asked at its first meeting to consider the answers to questions like these:

How important is the pursuit of medical education?

Are physicians handling the matter as well as could be expected?

Is it reasonable to expect that every qualified applicant should be able to get a medical education?

Should the AMA press for more money from the government and foundations to finance research?

What are today's priorities of medical concern?

What should the medical profession and the AMA do about problems of health care?

Are we on the right track in pursuing the principle of voluntary health insurance?

Assuming it is necessary to overcome conditions of deprivation in the slums in order to provide good health care, what are the priorities—housing, educational facilities or health care facilities?

Held First Meeting

The committee held its first meeting September 5, 1968. The second meeting was March 20, 1969. The third is scheduled for June 16.

The first meeting was mostly a get-acquainted session between members of the committee and the officers and executives of the AMA.

At its second meeting, the committee started to get down to business. It requested that three reports be prepared by the Association for consideration of the committee at its June session.

The papers that are now being prepared are:

1. Malnutrition and hunger in the United States.
2. Drug dependence and the whole picture of the use and abuse of drugs.
3. Financing health care through income tax credits for health insurance.

Members of Committee

The eight members of the Advisory Committee on Health Care of the American People are:

Ann Landers, of Chicago, often called one of the 10 most influential women in the world and author of the world's most widely syndicated newspaper advice column.

Kermit Gordon, economist and president of the Brookings Institute in Washington, D.C.

J. Irwin Miller, chairman of the board of Cummins Engine Company, Inc., of Columbus, Indiana, and former president of the National Council of the Churches of Christ in the U.S.A.

The Rev. Thomas J. O'Donnell, SJ, director of the Jesuit Residence in Hot Springs, North Carolina. Father O'Donnell is an author, editor and theologian

and is former dean of students and lecturer in medical ethics at Georgetown University of Medicine.

Charles B. Shuman, of Chicago, president of the American Farm Bureau Federation.

Edward Swayduck, of New York, president of Local Number One of the Amalgamated Lithographers of America.

Chairman of the committee is Charles E. Odegaard, Ph.D., president of the University of Washington in Seattle, and member of the National Council on the Humanities and the National Advisory Health Council of the Public Health Service.

Vice-Chairman is Judge Warren E. Burger of the U.S. Court of Appeals in Washington, D.C., and former assistant attorney general of the United States.

Maintain Contact

The Association hopes to maintain contact not only with distinguished laymen, but also with distinguished scientists in medicine and other fields. That, too, is being arranged.

In January, 1969, an organizational meeting was held by selected officers and staff members of the AMA, plus three outside physicians. Their purpose was to select members and formulate the mission for a 15-member Advisory Committee on Medical Science.

That meeting did not settle the matters of either membership or mission, and the organization of the committee is still pending.

Sophisticated Scientists

The group at the first meeting, however, did express the feeling that such a committee, if it is to be successful, must be composed of very sophisticated scientists in both the medical and behavioral fields. They also felt that such a group would have to be in operation, with frequent meetings, for at least six months before it would begin to be really effective.

One of the newest committees established by the AMA is responsible for tackling one of the biggest and most important jobs facing medicine and the nation today.

At its meeting in March, the Board of Trustees voted to establish a Committee on Health Care of the Poor. The committee will include representation from the Board of Trustees, the House of Delegates, the Council on Medical Service, the Committee on Maternal and Child Care, the Committee on Aging and the Speaker or Vice-Speaker of the House of Delegates.

Relate to Problems

The principal duty of the committee will be to relate to the problems of health care of the poor . . . to conduct in-depth studies of the subject with spe-

cific emphasis on the responsibilities and role of the AMA . . . and on completion of such studies, to recommend whatever action seems appropriate.

It will be the continuing responsibility of the committee to supervise implementation of its adopted recommendations as they are assigned to the various departments, councils and committees of the Association . . . and to report regularly to the Board of Trustees.

Membership on the committee has not yet been named. However, Dr. Long, as chairman, and Dr. Kernodle have been chosen to represent the Board of Trustees.

Internal Problems

A more internal problem is being approached by the Quinn committee—the Ad Hoc Committee to study the modus operandi of the Scientific Sections.

This committee tentatively submitted a report to the House of Delegates at the Annual Convention in 1968. However, the report was withdrawn before assignment to a reference committee.

The Quinn committee will complete its deliberations on May 16. Its two major recommendations will be as follows:

1. That the scientific sections of the AMA be maintained.
2. That each one establish a section council, composed of six to 10 members made up of representatives of the major specialty societies in each specialty.

Council Representatives

For example, the council of the Section on Internal Medicine would include representatives of the

American Society of Internal Medicine and the American College of Physicians.

Whenever there are two or more groups in the specialty, membership on the section council would be proportionate to AMA membership within each specialty society.

The section council would then appoint the section delegate and alternate delegate to the AMA House . . . would appoint a representative to the scientific assembly for the scientific program . . . and appoint a representative to the scientific assembly for exhibits.

Under these recommendations, the specialty medical societies would be given a position in the development of the AMA's scientific program . . . as well as representation in the AMA House of Delegates.

Conclusion

In conclusion, I would like to emphasize that all of the changes being made and those that will be made in the functions and objectives of the AMA are designed to increase the effectiveness, the flexibility and the expertise of the Association to meet the challenges of the changes taking place throughout medicine.

Advances in science . . . changes in education and research . . . and particularly the changing relationships between medicine and government . . . and between medicine and society . . . demand new approaches to new problems.

The AMA is preparing itself to meet whatever comes.

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San Francisco, Calif.*

CONGRESS ON OCCUPATIONAL HEALTH TO MEET IN SEPTEMBER

The 29th Annual Congress on Occupational Health will be convened for a two day scientific meeting on September 15-16, 1969, at Stouffer's Riverfront Inn, St. Louis, Missouri. The Congress is sponsored by the Council on Occupational Health of the American Medical Association.

One of the highlights of the meeting will be a luncheon presentation by Dr. Charles A. Berry entitled, "U.S. Man on the Moon." Dr. Berry is Director of Medical Research and Operations for NASA's Manned Spacecraft program, and his discussion of the Apollo 11 moon landing should prove to be an interesting look at the future of space medicine.

Twenty other guest speakers will cover more "earthbound" matters including pollution and radiation problems, medical problems involved in the hiring of the hard-core disadvantaged, and three symposiums on aviation medicine, agricultural and occupational hazards, and the measurement of permanent partial impairment for workmen's compensation. Medical directors for several of the country's largest industrial and manufacturing concerns will appear on the program.

No registration fee will be charged for attendance, and the Congress is approved for 10½ elective hours credit by the American Academy of General Practice.

Specific diagnosis of the type of lipid disorder is necessary before effective treatment can be instituted.

Diagnosis and Treatment of Lipid Transport Disorders

ROBERT I. LEVY, M.D., *Bethesda, Md.*

ALL THE BLOOD LIPIDS circulate bound to specific proteins. When lipid transport is viewed in terms of these lipid transport proteins (lipoproteins) rather than in terms of any individual lipid (cholesterol, triglyceride), greater specificity and definition can be imparted to the study and understanding of lipid transport disorders.

The differentiation of hyperlipoproteinemia may be accomplished by sequential preparative or analytical ultracentrifugation. For most clinical purposes simpler electrophoretic systems are adequate. Using paper or agarose gel electrophoresis one can obtain patterns that correlate well with ultracentrifugal patterns and at a fraction of the cost. Lipoprotein electrophoresis on paper and gel is rapidly becoming a routine procedure offered by many commercial and hospital laboratories.

There are at least five abnormal lipoprotein patterns that may be associated with hyperlipidemia. Each pattern is distinguished by an increase or abnormality in one or more of the normal serum lipoproteins. The lipoprotein patterns are not necessarily specific for a single disease. They may be primary, many of which are also familial, or secondary to a host of different acquired disorders. The abnormal patterns are accompanied by clusters of clinical manifestations that allow them to be considered different syndromes.

Type I

This lipoprotein pattern is indicative of an inability to clear dietary fat (chylomicrons). It is nearly always familial and in its severe form a rare dis-

order. The patients are usually young and have creamy plasma, lipemia retinalis, hepatosplenomegaly, eruptive xanthomata and bouts of abdominal pain associated with ingestion of dietary fats. After standing in the cold a discrete cream layer forms in the plasma of these patients. Plasma cholesterol levels may be normal or elevated; triglyceride concentrations are grossly elevated (often above 5,000 mg per cent). The familial disorder is recessively transmitted and is characterized by a deficiency in one or more of the enzymes involved in the clearance of fat from the circulation. Therapy is relatively simple. Diets low in fat result in a dramatic clearing of the hypertriglyceridemia and resolution of the associated abdominal complaints. There is no effective drug available now for the treatment of Type I. Supplementation of the diet with medium chain length triglycerides (MCT) often makes the diet more palatable.

Type II

Type II or hyperbetalipoproteinemia is a common pattern found at all ages. It is characterized by a marked increase in otherwise normal beta lipoproteins. Though the plasma is almost always clear, cholesterol levels are often in the 300-600 mg per cent range with normal or only modestly elevated plasma triglycerides. Type II patients may have xanthelasma, arcus juvenalis and tendon and tuberos xanthomata. Of note is the associated premature coronary vessel disease and the often striking family history of early death. This makes it important for all physicians to recognize that the Type II abnormality is often familial and transmitted as a dominant trait with essentially complete penetrance. Though the

Type II pattern may be secondary to excessive dietary cholesterol intake, myxedema, myeloma, liver disease or nephrosis, these causes can be quickly evaluated; and when ruled out, a Type II patient's family should be screened, for the patient's mother or father and 50 per cent of the patient's siblings and children (diagnosable as early as age one) will have hyperbetalipoproteinemia. Therapy for all of the secondary hyperlipoproteinemias should be directed at the acquired problem, i.e., thyroid replacement for myxedema. When this is not possible or the disorder is primary, specific therapy should be directed to the hyperlipoproteinemia. Dietary therapy for Type II emphasizes a reduction in cholesterol content to below 200 mg per day (avoidance of eggs, many dairy products, and fatty meats) and consumption of increased amounts of polyunsaturated fats. Most of the drugs available for hyperlipoproteinemia have little effect. Cholestyramine, a bile acid sequestrant, in doses of 16-32 gms per day, has resulted in impressive reductions in cholesterol and beta lipoprotein levels. With a combination of a low cholesterol diet and cholestyramine, lipid levels can often be brought into the normal range in the Type II subject.

Type III

Type III is a relatively uncommon pattern associated with the presence in plasma of abnormal beta lipoprotein forms. Patients have clear, cloudy, or milky plasma with elevations of both cholesterol and triglyceride concentrations into the 350-800 mg per cent range. These patients often present in the third or fourth decade with planar xanthomata (orange-yellow lipid deposits in the creases of the palms of the hands) as well as tuberoeruptive (elbows, knees, and buttocks) and tendon xanthomata. Commonly, both premature coronary and peripheral vessel disease occurs. Type III is usually familial and apparently transmitted as a recessive trait. Dietary therapy for Type III emphasizes calorie control and a diet balanced in fat, carbohydrate, and protein and low in cholesterol. Clofibrate, 2 gms per day, is delightfully effective, especially when coupled with the balanced therapeutic diet: it results in a complete normalization of plasma cholesterol and triglyceride concentrations, resolution of external xanthomatosis and apparent improvement in peripheral vessel flow.

Type IV

Type IV is a very common lipoprotein pattern, most frequently seen after the second decade of life and often associated with diabetes mellitus and premature atherosclerosis. It is characterized by an isolated increase in endogenous triglyceride (prebeta-

lipoproteins). The plasma may be clear, cloudy or milky depending upon the triglyceride concentration. Cholesterol levels are frequently normal. The patients usually have no external stigmata. The pattern sometimes reflects a familial disorder transmitted as a dominant with delayed expression. It may be that several different mutations are responsible. It is often, however, secondary to other metabolic disorders and whether primary or secondary it is usually exacerbated by obesity. Dietary therapy emphasizes reduction to ideal body weight, and reduction in the carbohydrate and alcohol content of the diet with a concomitant increase in the amounts of polyunsaturated fats. Diet therapy alone often results in total normalization of the plasma lipids in Type IV. Drugs like clofibrate, D-thyroxin and nicotinic acid have been variably effective.

Type V

Type V is frequently seen secondary to acute metabolic disorders like diabetic acidosis, pancreatitis, alcoholism and nephrosis though it may be familial. Patients with Type V usually become symptomatic after age 20 and may have all the features of Type I: creamy plasma, hepatosplenomegaly and bouts of abdominal pain often with frank pancreatitis. The patients often have multiple abdominal scars after years of occult abdominal pain. They appear to be intolerant to both dietary and endogenous fat and have triglycerides in the 1,000-6,000 mg per cent range with mildly to markedly elevated plasma cholesterols on an unrestricted diet. Abnormal glucose tolerance and hyperuricemia are frequently associated. Diet therapy emphasizes caloric restriction, reduction to ideal body weight and a diet high in protein and low in carbohydrate and fat. Clofibrate, D-thyroxin, nicotinic acid, may all modestly reduce the triglyceride concentration, but often not to a significant degree.

The importance of going beyond the simple determination of cholesterol and triglyceride should be apparent. Five different types of hyperlipoproteinemia have been briefly characterized and discussed. Each is associated with a specific lipoprotein pattern that may be familial or acquired. Each is associated with specific clinical and laboratory signs and at least three of the Types (II, III, and IV) are associated with premature vascular disease. Each type responds differently to dietary manipulations and specific drug regimens. Perhaps for the first time, it is now possible for the clinician to apply relatively specific therapy to the patient with a lipid transport disorder.

*Molecular Disease Branch
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Stones and Bones (Renal Lithiasis)

JOHN R. HANDY, M.D.,* ALFRED J. BOLLET,[†] M.D., and J. ROBERT RINKER,[‡] M.D.

DR. HANDY: I don't think the cause of most kidney stones is known, and I don't think medical treatment for most stones has been effective. Perhaps these are the two most important things to say today. Stones have plagued mankind for a long time, and there are many colorful descriptions of various aspects of kidney stones in the very earliest of medical writings. Today's conference will touch on some clinical points of renal lithiasis but will deal mainly with etiologic considerations. Three fairly recent publications are of particular note for those who wish to pursue the matter further, two dealing with etiology,^{7, 9} the third being clinical.⁸

I might define stone disease clinically. Typically, a middle aged male presents with flank pain. If the stone is localized in the kidney, the pain is localized over the kidney. As the stone moves down the ureter, the pain moves down, and when the stone reaches the junction of the ureter and the bladder, the pain is often in the testicle in males and in the labia major in the female. This may be associated with sweats, but in my experience chills are not common and fever is uncommon unless there is a suprainfected infection. These attacks will usually last several hours to a few days and are partially relieved with opiates. Pain is often absent as a stone passes through the urethra, although the patient is conscious of passing and often collects the stone. This is the way the patient presents to the doctor, and it is a memorable experience for both patient and doctor. The female stone-formers with whom I've talked who have delivered children prefer child birth pain to the pain of kidney stone, although I've heard it said that child birth pain is quickly forgotten.

Types of Stones

I think it of use to mention certain features of the various types of stone. Calcium oxalate is the most common followed by calcium phosphate. Frequently patients have calcium oxalate and phosphate together in the same stone. Then in decreasing frequency there is magnesium ammonium phosphate, uric acid, cystine, and, last and least, xanthine, which I won't mention again because of its rarity. Calcium phosphate and oxalate are the great garden-variety stones, and it is here where therapy has been most difficult. Recent experience suggests oral phosphates may be beneficial to treat these stones, and we have a study under way in this institution to test this drug. Magnesium ammonium phosphate stones are thought by many to be manifestations of an infected urine, so such stones direct the physician to cleansing the urinary tract of bacteria. One out of 10 patients with gout have uric acid stones. However, most uric acid stone formers don't have hyperuricemia, and it would seem that the genetic disease of gout is usually not present in the uric acid stone former. These stones are soluble in alkaline urine and precipitate in acid urine. They are often treated with sodium bicarbonate to alkalinize the urine and more recently allopurinol to reduce uric acid formation. Cystine stones are very rare and are part of the disease cystinuria characterized by abnormalities of the metabolism of the amino acids arginine, ornithine, lysine, and cystine. The only clinical manifestation of cystinuria is cystine stones. Patients with cystine stones may have severe stone disease but only 1 to 3 per cent of cystinurics have kidney stones. Because cystine precipitates in an acid urine, these stones are treated with alkalinization of the urine and penicillamine. Penicillamine combines with cystine in the urine to form soluble complexes. From the above facts the importance of stone analysis is

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readily apparent, as proper diagnosis and therapy depend on the type of stone.

There are a few points we have found of use in differential diagnosis of stones. It is helpful to know the urine pH. To measure urine pH we customarily have the patient void between 5:00 and 6:00 a.m. and then check the pH of the next urine passed before breakfast. If the urine pH is less than 5, it's often a uric acid stone. If the pH is between 5 to 7, it probably is a calcium oxalate stone or a mixture of calcium oxalate and calcium phosphate. If the pH is greater than 7, it is probably a calcium phosphate stone. A urine pH of 7 with a magnesium ammonium phosphate stone certainly suggests the presence of infection. Since the normal urine pH is around 5.5, most stones are calcium oxalate. Most stones in my experience have been a mixture of oxalate and phosphate. Because uric acid stones are correctable with therapy, and because uric acid stones are consistently associated with an acid urine, urine pH is quite important in diagnosing this disease. Uric acid stones are radiolucent, so radiolucent stones seen with IVP or retrograde x-ray studies with a urine pH less than 5 suggest a uric acid stone. Alkaline urine is strongly against a uric acid stone. Calcium phosphate stones may form in a concentric lamellar structure which can be identified radiologically, while calcium oxalate is more apt to appear homogeneous radiologically. In this way the radiologist can sometimes help to identify the chemical composition of an unpassed stone. Most patients with hyperparathyroidism have calcium phosphate stones, so the radiologist can at times provide clues to this diagnosis if the stones are laminated.

One out of 1,000 people in the United States have a kidney stone. Of every hospital admission in the United States, one out of 100 is due to a stone or a complication of stone. Of every patient who has an attack of stones, one out of five can expect to have another attack. Four out of five stone formers will have no etiology found if one takes all the series in the literature into account. In my experience it is even more unusual to find the cause and 90 to 95 per cent of patients that I have seen have had no recognized etiology. This is probably a reflection of the fact that stone disease in the southeastern United States may be different from the rest of our country. The most common correctable cause is hyperparathyroidism. If one is fortunate enough to have a patient with uric acid or cystine stone, therapy can be enjoyable.

Importance of Mineralization

It should be mentioned that not all stones are bad. For instance, the lowly oyster not only uses mineralization to produce his home but can use a grit

of sand trapped in his soft substance to create the economically and esthetically important pearl. This is an illustration of the enormous importance of mineralization in the biologic world as well as in human health and disease.

We should touch on a few of the many factors that at one time or another have been thought of importance in stone formation. Obviously urine pH is of interest. Everybody knows that if you put salt into acid, the salt goes into solution. However, stone formers usually have no different urine pH than do patients who don't form stones. Furthermore, therapeutic trials to manipulate the urine pH to treat kidney stones are notable in their failure, except for possibly cystine and uric acid stones. Paraplegics, who often get kidney stones, have normal urine pH. So urine acidity appears not to be the sole factor in kidney stone formation.

Urine calcium has also attracted attention because all stones contain calcium with the great majority of stones containing calcium as the main cation. The evidence that urine calcium content or concentration is of importance in stone formation is unimpressive. Some investigators have found elevated urine calciums in from 16 to 66 per cent of stone formers, while others have found no difference between stone forming and normal urine. So that's not the whole answer. From the opposite point of view, what about the patients with idiopathic hypercalcuria? There are a fair number of people who have too much calcium in their urine, and these people by-in-large do not get kidney stones. Again this suggests there must be something more than calcium that is of importance in renal calculus disease. Calcium in the urine is a very complex thing. It usually is measured as total calcium expressed as mgm./24 hrs. or mgm. per cent, but this expression does not take into account the many ways that calcium may be bound or chelated—i.e.—to citrate. Ionized calcium in the urine of stone formers and non-stone formers is the same. There is evidence that the ratio of calcium to sodium in the urine is important rather than the calcium alone.¹⁰ Although urine calcium has attracted much attention as being etiologically important, its role in the genesis of stone is obscure.

Infection a Cause

Infection has been said over the years to be causative of kidney stones, and it is true chronic stone formers often have pyelonephritis. Fifty per cent of stone formers in the experience of some have pyelonephritis. However, 50 per cent don't have demonstrable pyelonephritis and, furthermore, pyelonephritis is common among all autopsies while kidney stones are not. The bacterium that has been often incriminated is proteus. Experimentally, the

STONES / Continued

kidneys can be infected with proteus, changes of pyelonephritis follow, and eventually magnesium ammonium phosphate kidney stones form. However, most patients who have stones have *E. coli* in their urine, and when kidneys are infected experimentally with *E. coli*, stones do not form. Furthermore, stones can be produced in germ-free rats. If infection is present, it must be treated as part of the therapy for the stone. While stone and infection often have to be treated together, it appears that the infection most likely follows the stone rather than causes it.

Stasis has been thought to be important. It's reasonable to think that if urine flow is hindered, calcium will precipitate; however, a partially obstructed kidney puts out a dilute urine rather than a concentrated urine. If the ureters in rats are partially occluded for prolonged periods of time, stones will appear in the kidneys. Acute partial occlusion of a ureter won't produce stone and neither will total occlusion or denervation. Certainly most stone formers do not have obstruction, at least as judged by the IVP, although admittedly this may be a gross technique when one is talking about the fine structural integrity of the distal collecting ducts. I have been impressed with a number of patients with kidney stones whose IVP's are reported to show structural abnormalities of their distal collecting duct system. I haven't been able to find much about this in the literature, but apparently it's called tubulorectasis and seems to be in that group of diseases called "sponge kidney disease." Of about 25 stone formers we have investigated in some detail, three turned out to have tubulorectasis.

Vitamin A deficiency is important in some stone belts. In parts of Egypt and India vitamin A deficiency is present and there is a high instance of kidney as well as bladder stones. This is thought to be due to a vitamin A deficiency-induced desquamation of the epithelial cells which serve as nidi for the stone. However, in the Israeli Jew and in the American southeastern white patient the instance of kidney stones is quite high and vitamin A deficiency is not present. This clearly is not the sole factor.

Calcium Deposits Common

Microliths are deposits of calcium that are phagocytized by macrophages in the interstitial tissue surrounding the distal collecting duct. These macrophages then coalesce and appear histologically as calcium deposits. They are extremely common, in fact there is evidence in the literature suggesting virtually every person has microliths. What these structures have to do with stone formation is unknown. These minute calcium deposits seem to occur in the lym-

phatics and one investigator feels abnormalities producing altered lymph flow are responsible for stones.³

I have found Dr. Randall's work¹¹ on stones to be of considerable interest. I was particularly impressed with his courage. He tried several years to experimentally induce stone disease in animals, finally turning to the autopsy table to seek the answer to this problem. He carefully cut the kidney so as not to dislodge any possible calculi and looked at the papilli with a magnifying glass. On his 27th kidney he found what he was looking for, and I have to admire anybody who'll pursue a negative thing 27 times. In the collecting ducts of his 27th kidney were streaks of white crystalline material. Dr. Randall's study indicates initially there is alteration of the connective tissue in the interstitium surrounding the collecting duct. This is followed by sloughing of the overlying epithelial lining and then the precipitation from the urine of calcium on this area of exposed interstitial substance. Fourteen to 19 per cent of all patients autopsied have Randall's plaques. Dr. Randall thought that this was the primary lesion of kidney stones. However, the instance of Randall's plaques in the general population is higher than the instance of kidney stones in the same population. Furthermore, the Bantu native, who rarely gets kidney stones, has about a 4 per cent instance of Randall's plaques, so Randall's plaques are not the only etiologic agent in the genesis of kidney stones.

During the last few years something has been learned of mineralization in various biologic systems. For instance, in bone, it is thought collagen acts as the nidus on which the crystal, hydroxyapatite, is formed. There is evidence phosphate is initially attracted to the amino acid hydroxylysine which is in the collagen, the calcium following passively. This is the beginning of bone crystal growth. Furthermore, it appears as if large molecules containing both protein and polysaccharides (protein-polysaccharides) may be important in regulating mineralization in as much as the sugars of the molecule are charged, thus providing a mechanism to regulate the behavior of ions going into or leaving a crystal. In urine large protein-polysaccharide molecules called uromucoids have been identified, and considerable effort has been spent trying to identify the importance of these substances in the mineralizing disease called kidney stones. For several years Dr. William Boyce and his colleagues at Bowman Gray Medical School have investigated uromucoids. They originally thought this substance originated in the distal part of the collecting system and was responsible for the start of a kidney stone. With improved techniques they have demonstrated this substance in the urine of normal people as well as in the urine of stone formers. It's also present in the

serum of stone and non-stone formers. The status of these substances is uncertain.¹

Inconclusive Evidence

Other studies have investigated inhibitors of calcification in the urine, the idea being that deficiencies of these inhibitors will cause stones. Small molecular weight peptides that inhibit mineralization have recently been found in the urine—something Dr. Bollet will discuss later. Other substances that have been considered as possible inhibitors include urea and certain amino acids, but the evidence incriminating these factors is inconclusive. Because there is so much citrate in urine and because this acid chelates calcium, it has attracted attention; however, the urine citrate abnormalities of patients with stone appear to be the result of rather than the cause of the kidney stones. Inorganic pyrophosphate has been of recent interest. This substance will inhibit calcification. It has been shown in male stone formers of ages 30 to 40 that inorganic pyrophosphate is decreased in the urine and this is the peak age instance of stone disease in males. However, there is so little pyrophosphate in the urine compared to the amount of calcium that stoichiometrically it doesn't seem very important. In the past, hyaluronidase has been given parentally to patients to break down protein polysaccharide complexes, hoping that products of this breakdown would be filtered in the urine and perhaps these colloids would inhibit calcification. It should be mentioned that hyaluronidase therapy is no longer used.

The relationship between the high molecular weight substances of urine called colloids with the low molecular weight substances called crystalloids has been studied by Dr. C. W. Vermeulen and his colleagues.¹² Uromucoids and albumin are examples of colloids, while calcium, phosphate, urea, glucose, and sodium are some crystalloids. These investigators feel because colloids have the capacity to absorb crystalloids on their surface and in this way keep crystalloids soluble, abnormalities of this relationship induce stones.

Thus, research on the etiology of stone disease has centered around identifying abnormal substances that may start mineralization (i.e., uromucoids), or seeking abnormalities of inhibitors of mineralization (i.e., peptides), or studying the relation of colloids and crystalloids.

Clues in Studies

Perhaps clues to the etiology of stone lie in epidemiologic studies. There are certain stone “belts” in the world. A world-wide view of kidney stone belts has been assembled by Dr. Arthur Butts⁴ (Fig. 1). It's the only such map I've been able to find in the literature. There are suspicious things about this map; for instance, notice Norway and Sweden. I don't know the background of these two countries, but it seems unlikely that a political boundary would so nicely separate the instance of kidney stone. At any rate I'd like to specifically talk about South Africa and Israel.

First looking at South Africa, it will be noticed

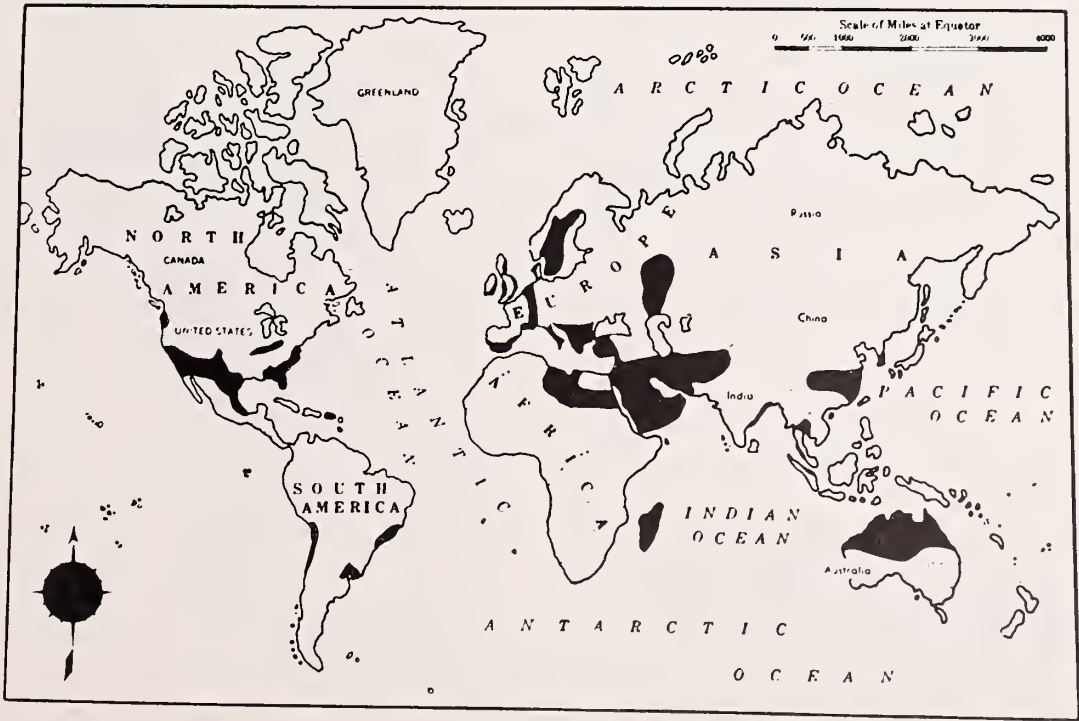


FIGURE 1
A world wide view of stone belts assembled by A. J. Butts.⁴

STONES / Continued

that there are no stone formers there.¹³ The Bantu native has been studied extensively in regard to his ability not to form kidney stones. It would seem that anybody with a substance he thinks is important in causing kidney stones gets himself a grant, goes to Africa, and measures this substance in the urine of the Bantu. It is of interest to find why the Bantu doesn't have stones because perhaps this would give us a clue as to why the rest of us do get stones. Initially looking at this map one would perhaps incriminate genetic reasons for the lack of stones in the Bantu. However, the problem is complex. For instance, the Bantu only eats about one third of the amount of calcium in his diet, has a greater fecal mass, and has a higher urine citrate than does the white African. There are many other differences between the Bantu and the white African that have been studied, but suffice it to say the reasons for the Bantu's resistance against kidney stones is not understood.

Israel is of particular interest because of the migration of the different Jewish populations during the establishment of this country in 1948. An elegant study⁵ was done of the appearance of stone in these people. One particular group of immigrant Jews sep-

arated into two groups, one going to a hot, dry climate and the other to a temperate, hot climate. The group who went to the hot, dry climate had a higher instance of kidney stones than the group who went to the temperate, dry climate. Furthermore, it was noticed the Jews immigrating from central Europe would not customarily drink more water when exposed to harsh conditions of vigorous physical work at very hot temperatures, while Jews who had migrated from North Africa would by habit drink larger amounts of water when under conditions of extreme temperature. This study concluded that the amount of water consumed was important in the genesis of stone disease. Many in the field of kidney stone research feel water intake is one important factor in stone disease.

Epidemiology of Stones

Figure 2 shows the epidemiology of stones in the United States.² As you see, we are in a stone belt in Georgia. This is even more impressive when one realizes that the American Negro is a descendant of the Bantu and that he doesn't develop stones as readily as does the white Southeastern American, although the American Negro has a higher instance of stone than does the Bantu. The figure of one out of 1,000 people in the United States having kidney

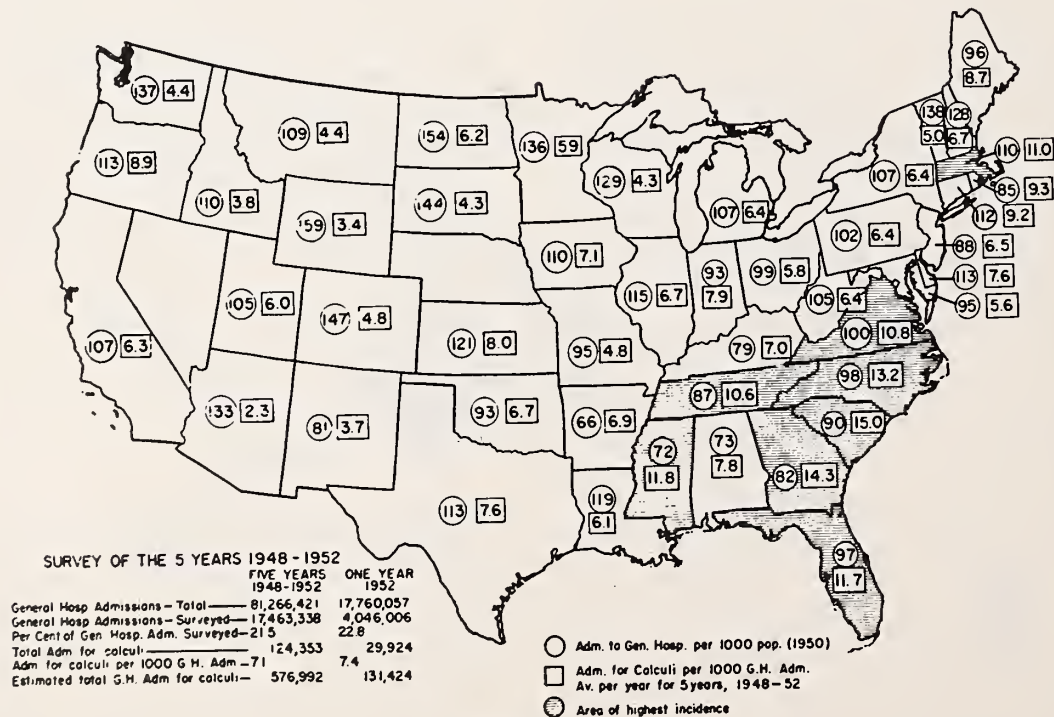


FIGURE 2

Incidence of urinary calculi in the United States during the years 1948 to 1952, by Boyce, Garvey, and Strawcutter.²

stones is really much higher in the Southeastern United States. No adequate explanations are available to explain these findings.

I'd like now to ask Dr. Bollet if he would comment on some other aspects of kidney stones.

DR. BOLLET: I'd like to review with you some of the work concerning inhibitors of calcification that has mainly come out of the laboratories at Johns Hopkins, with particular attention to the recent work of Dr. John Eager Howard and his associates. Studying rickets, they observed that cartilage from animals or patients with rickets would calcify if put into normal serum, whereas the serum of patients with rickets or osteomalacia would not calcify the rachitic cartilage. The problem of rickets thus was related to the change in the concentration of calcium and phosphorus in the serum, and these changes were responsible for the failure of normal bone formation in the patient. By altering the concentrations of calcium and phosphorus in the media of their *in vitro* model, they concluded the product of the concentrations of calcium and phosphorus had to be greater than 30 in the serum for cartilage to mineralize *in vitro*. The exact concentration of the calcium or phosphorus was not important as long as the product of the two concentrations was greater than 30.

Since the normal ion product in blood is well above 30, the question arose as to why we aren't all depositing calcium everywhere; why is mineralization limited to the places where it is supposed to occur, and, secondly, why doesn't urine always form stones, since the ion product in urine is perhaps 100 times the amount necessary for an artificial solution to cause mineral deposition in rachitic cartilage *in vitro*? In additional studies, Dr. Howard found that serum from uremic individuals did not cause mineral deposition even though the ion product was usually above 30. In the uremic patient the serum phosphorus may be 7 mg. per cent, with a calcium possibly of 7 mg. per cent; yet this solubility product of 49 would not cause *in vitro* mineralization of the cartilage. Why doesn't metastatic calcification occur more often in uremia?

With this background Dr. Howard found that urine from normal individuals did not cause calcium to be deposited but urine from stone formers generally would allow mineral to be deposited in the cartilage—even if the ion concentrations in the normal and the stone-formers' urine were the same. Dr. Howard referred to the urine from the normal as being "good," while the urine of the stone formers, which allowed mineralization, was called "evil"—a nomenclature Dr. Howard attributes to his religious background.

Unknown Inhibitor

Since it wasn't simply a matter of the ion product determining whether mineral deposition occurred, there must be an inhibitor present in the normal urine which would prevent mineralization and thus was responsible for the "good" quality of the urine. By varying the magnesium concentration, this ion was ruled out as being important. Another likely substance was inorganic pyrophosphate, which Dr. Handy has mentioned, since the unknown inhibitory substance was dialyzable and had low molecular weight, as does pyrophosphate. But the unknown inhibitor was stable on heating to 100° F. at pH 1 whereas pyrophosphate is not. From then on the study of this inhibitor grew progressively more interesting.

The material that seems to be responsible for this "good" quality of urine has been isolated. Various purification steps finally produced two peptides which will inhibit mineralization in the *in vitro* cartilage system.⁶ One has a molecular weight of 580 and six amino acids while the other has a molecular weight of 950 and contains nine amino acids. Both contain aspartic acid, glutamic acid, serine, and glycine. One consists of aspartic acid, glutamic acid, serine, glycine, alanine and threonine. This hexapeptide is quite capable of inhibiting calcification in urine or serum, or artificially constituted calcifying solutions. In the systems in which they work, Dr. Howard's group found that they need only six micrograms to prevent mineral deposition from occurring, whereas normally 24 hour urines contain approximately four milligrams of inhibitory peptide.

The mechanism of action of these substances is quite interesting; apparently it is not related to chelation or binding of calcium. When just enough hexapeptide is used to inhibit calcification partially, there is no change in the ratio of the calcium to phosphorus that is deposited. On a molar basis the hexapeptide is capable of blocking 16,000 times as much mineral, so its ability to prevent mineralization is far beyond anything that could have been caused on the basis of chelation.

Crystal Poisons

The substance can be placed in the general category of crystal poisons. These are substances that are well known in other fields—i.e.—in plumbing and in the chemical industry these substances are used to prevent incrustation of pipes; apparently, in those of us who don't form stones these substances of endogenous origin are excreted in the urine and prevent incrustation of our pipes. The mechanism of action is probably one of binding to very small crystals as they begin to form, blocking growth of the

STONES / Continued

crystal. It takes very small amounts of these "poisons" to stop crystal growth.

Recently there has been interest in the effect of parathyroid hormone on mitochondrial calcium content, and the relationship of this effect to bone metabolism. One micromole of inhibitor peptide was found in 60 mg. of rat liver mitochondria, with a turnover time of eight to 10 days in the mitochondria. These observations have led to the hypothesis that this material originates in mitochondria, enters the blood, and is excreted in the urine. It may then serve to protect us from concrete formation in many sites in the course of wandering through the body. I think we may find it is of interest in the future to go back to the question of the relationship of this substance to the development of bone disease in uremia.

In summary, these hexapeptides apparently have considerable importance in controlling mineral deposition. Either these or similar substances may be involved in controlling mineral deposition in bone, or in preventing the mineralization of collagen in sites which are not supposed to mineralize, such as tendons. I expect we'll hear more about these substances as work on their structure, and possible artificial synthesis of them, is accomplished. It is conceivable that they will be of therapeutic use in kidney stone disease in the near future.

DR. RINKER: I wasn't asked to prepare a text, but I do appreciate the opportunity to correct a few things that were said. First I want to qualify Dr. Handy's statement about treatment being ineffective. If we break it down, 80 per cent of patients never have another stone, and in the remaining 20 per cent we can do things in half of them so that they won't have another stone. This leaves only 10 per cent that we don't ever want to see again. I always teach my students, "When the stone is less than half a centimeter in diameter, the patient should get morphine and water and hope he passes it; if he becomes infected, then your hand is forced and you have to do something." I asked this question on a final examination once, "When would conservative treatment of a stone in the ureter have to be abandoned?" One student answered, "When the patient threatens to get another doctor." I figured anybody as precocious as that in the ways of the practice of medicine would do all right.

As to pure stone, we don't see quite as many as Dr. Handy has probably implied because these stones are laid down in layers like an onion, the layers varying with the seasons of the year and under different dietary conditions. This will vary the constituents of the surface layer on the stone at dif-

ferent times. On analysis we often get several different constituents but we label it as the predominant one. Sometimes it helps, but not as often as we had hoped.

Now I want to violently disagree with Dr. Handy's statement about stasis, if I understand him correctly. He said, "Stasis is not a factor in stone formation." I think that's absolutely wrong because anywhere we have partial obstruction these patients have a much higher percentage of stones. Actually when we see a patient with a stone in his kidneys we immediately ask ourselves where is his obstruction? Why does he have a stone? So, I'm glad to have an opportunity to say something about that.

About the alleged lower incidence in Negroes, I don't know whether it's true or not. Urologists have never agreed on this point. Economic factors are important and we're not so sure that as many of the Negro patients ever saw a doctor about their stones as the white patients did. It seems to me that we have just as many Negro patients as white who have stones. In any event it's not a helpful statistic in seeing patients.

These conferences are taped weekly and are selected and edited by Dr. A. Calhoun Witham, Professor of Medicine, Medical College of Georgia. The participants are principally faculty and house staff of the Department of Medicine, or Junior Medical Students assigned to the patients. Members of other departments are so identified.

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With many common objectives and techniques, it is apparent that the Public Health physician and the psychiatrist in community mental health are actually very closely related colleagues.

Relationships Between Public Health and Psychiatry

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IN THE RECENT PAST Public Health and Psychiatry have had one thing in common—both have a reputation for being outside of the mainstream of medical practice. Perhaps it is quite appropriate then that we outsiders come together here at this meeting of the Medical Association of Georgia, to look at what we have in common.

Perhaps as a beginning we should look at the reasons we have each been seen as “outside” of the mainstream of medical practice. Public Health deals with prevention of illness and disability and the promotion of good physical health. Surely all that a Public Health physician does is based on sound medical science. In fact, his practice is generally more scientifically based than that of his colleagues in medical practice. What then is the cause of his estrangement? It seems to me that he is seen as “different” because his role is not that of a traditional medical practitioner. He does not work with individual patients in the idealized model of diagnosis and treatment pathology.

For Psychiatry the difference lies in the field of work—the psychological aspects of persons. The psychiatrist works with individual patients in the traditional model of pathology and therapy, but the subject area of the emotion and behavior are not the traditional biological areas of medical practice. Perhaps if psychiatrists limited themselves to a purely neurological kind of psychiatry, as many Europeans do, there would not be this estrangement. It is unfortunate that most of medicine has

become so biologically oriented that it shuns the psychological and sociological aspects of illness. We hear patients referred to by their pathology (i.e. “coronaries” or “gall bladders”) or by their treatments (i.e. “appendectomies” or “cobalt cases”). It is surprising how much this preoccupation with the biology of medicine has dehumanized medicine’s conception of its patients and alienated it from those specialties that are concerned with more than just the biology of individual patients.

Lost Awareness

But we each become so preoccupied with doing our “thing” that we lose touch with the full scope of the field of medicine. In a similar way public health specialists and psychiatrists have each been so preoccupied with their own pursuits that they have lost awareness of each other. Our estrangement is therefore not only from the overall field of medicine, but also from each other. Yet when we consider that the overall goal of medicine is the preservation of the physical and mental health of the public, and that the full scope of medical concern is a bio-psycho-social matter, we realize that we *all* belong as comrades in the field of medicine after all.

Public Health and Psychiatry have always had some relationships, especially around the admission of certain disturbed persons to the care of psychiatrists in state mental hospitals or in psychiatric units of general hospitals. In a few states public health departments have been responsible for some after-care services to former mental hospital patients, but this has generally been the duty of the public health nurses rather than the physicians.

* Associate Director for Mental Health Training and Research. Delivered at 115th Annual Session, Medical Association of Georgia, Savannah, May 3-7, 1969.

RELATIONSHIPS / Continued

Now, however, we see a whole new movement in the field of psychiatry which should bring the fields of public health and psychiatry much closer together. This new movement is the development of community mental health. To be sure, a fair portion of community mental health is everyday psychiatry practiced outside of the traditional private consulting room or hospital. But a major commitment of community mental health is to the same kinds of prevention and health promotion goals related to mental health that have long been the objectives of public health in the area of physical health.

In many instances the theoretical bases and the methodological approaches in mental health are exactly the same as those being used in public health, and, of course, the populations to be served are identical.

Strikingly Different

This whole area of community mental health is as strikingly different from traditional psychiatric treatment as public health is different from general medical treatment. Not all psychiatrists have embraced the notion of community mental health; a few remain actively opposed to the whole concept. But, then, there are still some general medical practitioners who do not embrace public health. This should not deter us. Let us look at some of the common concepts in community mental health and public health and some of the reasons we should cooperate in our endeavors.

The main goal of both specialties is the preservation of the health of a defined segment of the public. In public health the segment is usually defined by a political subdivision (city, county, or state) whereas in mental health it is the catchment area, whatever that may be (usually from 75,000 to 200,000 people). This, of course, is a very strange concept for the traditional psychiatrist who is used to working with only those patients who come to him and are accepted by him for services. The rest of the public is of no concern for him. The community mental health concept includes treatment of all persons in the catchment area that need such services. The needs for treatment are usually so great that treatment services are likely to consume most of the psychiatrist's time and attention. The demand for treatment services is usually so acute, and the work so familiar to the psychiatrist, that he may quickly fall into devoting all of his energies to treatment and very little to broader community activities. These same pressures also compel the psychiatrist to develop short forms of therapy and group therapy to save his time. The pressures also

force him to use other workers to extend his efforts to serve as many persons effectively as possible. There is very little room for traditional long term psychoanalytic therapy by a single psychiatrist in the community mental health center.

This notion of serving all of the mental health needs for the residents of a catchment area has also forced psychiatrists to be more concerned with very early case-finding when the problems can be managed with a minimum of effort. This function, of course, is comparable to the case-finding programs that Public Health has conducted for tuberculosis and venereal disease.

Early Case Detection

As public health physicians learned long ago, early case detection involves going out into the community to set up programs for finding persons with clinical cases that families may be hiding or cases that may still be asymptomatic. Similarly the early case detection in community mental health involves going out into the community to set up programs. The schools have proven to be an agency that lends itself to early detection since every child is required to attend school between the ages of 6 and 16. The psychiatrist may alert teachers to problem youngsters such as the excessively shy or withdrawn, the child with school phobia, the excessively aggressive child or those with early trends to sexual inversions. Similarly, outreach programs to personnel men or union stewards in industry may help to detect early alcoholics and get them to treatment before the man really hits the skids losing his job, his family and his self-respect so that a major rehabilitation job must be done.

Another area that has been the concern of the public health physician has been chronic illness. Similarly, the psychiatrist in mental health must be concerned with the chronically ill. The populations in our state hospitals are dropping sometimes dramatically. In some states there are only half as many persons in residence in the state hospitals as there were 10 years ago. Many of those persons still retain some vestiges of their schizophrenia, cerebral arteriosclerosis, or paranoia. Our society has recently come a long way in accepting the notion of a limited psychiatric disability. But many of these people need continuing support and supervision, especially if they are relatively alone in the world. Many need continuing medication—tranquilizers and anti-convulsants in particular. Others need help with domiciliary arrangements, day-care or 24-hour care. Nursing homes, which are a concern of the Public Health Department, may provide care for some of these persons, but most of these chronically ill mental patients need assistance in personal-care

homes rather than the skilled nursing care of a nursing home. The mental health unit's psychiatrist must oversee the care and services extended in these facilities, and provide occasions when the patients themselves are seen for check-ups on medication and general progress in their rehabilitation.

Another major area of concern to the public health physicians is primary prevention of illness. This area began with the control of contagious disease with programs of immunization against the offending organism, or somehow blocking the organism from reaching susceptible people (screening privies, pasturizing milk, or purifying water). More recently public health attention has extended to prevention of accidents and chronic disease. In mental health, the concerns for prevention are parallel despite the cry of many psychiatrists that we know nothing about prevention. Psychiatry has long supported specific programs to prevent cerebral toxic or noxious agents from causing brain damage or dysfunction. The dementia of pellagra, the symptoms of central nervous system lues, the brain damage of virus encephalitis and of lead encephalitis, and mental retardation from rubella and rubeola, are only a few of the organically leased strategies of prevention that have been of concern to the public health psychiatrist.

Concerned With Prevention

In a somewhat different model of prevention, the public health physician has been concerned with accident prevention and prevention of chronic illness. The strategies in these programs are not so specific and biologically oriented. Instead, they depend on education and organization of promotional campaigns among the public (i.e. urging and promoting the use of auto seat belts).

In a similar vein, mental health is concerned with prevention programs of a less specific nature and involving public education and promotion—at least with target groups. Thus we have programs to work with persons about to retire from industry, to give them anticipatory guidance regarding their retirements in order to prevent the anxiety and depression that so often hits a person upon compulsory retirement at age 65. Similarly, mental health staff should work with mothers in well-child clinics to help mothers prevent the crises some will experience around events such as introducing solid foods, toilet training and sibling rivalry when a new baby is on the way. There are several other kinds of preventive activities that are generally aimed at prevention of anxiety and emotional disturbances of various kinds. At present there are no specific preventive programs directed to the major psychoses since we

are not yet certain of the specific causes or courses of these illnesses.

Another area of program concern for the public health physician is that of positive health promotion. Perhaps programs of good nutrition and physical fitness programs are the best examples of positive health promotion. These involve health education and the organization of programs directed to broad groups of the public at large. Similarly the psychiatrist in community mental health is concerned with promotion of positive mental health. Sometimes this involves education programs in the public schools regarding issues of normal growth and development (i.e. boy-girl relationships, courtship and marriage) and sometimes it involves organizing and assisting with programs for healthy psycho-social development such as recreation programs, scouting programs, boys' clubs, etc.

Community Planning

Another area of common activity for public health and mental health physicians is in participation in community planning. Any public health physician can tell of the committees and commissions on which he is asked to serve to lend his health knowledge and insight to the planning process. This is especially likely in programs such as recreation, aging and urban renewal. Similarly the psychiatrist in mental health will be called upon as a participant in community planning with some of those same programs, but also for juvenile delinquency, anti-poverty programs and sometimes in welfare and educational programs.

With these common objectives and techniques, it is apparent that the public health physician and the psychiatrist in community mental health are actually very closely related colleagues. There are, of course, some substantial differences, but there are far more things in common. It is unfortunate that in some communities there is open antagonism between public health and mental health. More often the two have learned to work together to support each others' efforts and to combine forces whenever possible. Most often they have not been part of the same administrative organization, but they have found ways to overcome the differences in organization, terminology and objectives through their common overall goals.

Community mental health as a discrete subspecialty within psychiatry is less than 10 years old. There are many persons in the field of psychiatry who do not understand or accept it. Obviously in its broadest conception it is the epitome of the public health practice of psychiatry.

RELATIONSHIPS / Continued

Cooperation Needed

Public health physicians are most often among the leading proponents and organizers of community mental health centers. They should go a step further and help the psychiatrist in the center to implement a broad community mental health effort rather than letting him get bogged down in the treatment functions alone.

At the same time the psychiatrist in private practice should understand the goals of both public health and mental health and support both of them even if he personally prefers not to do that kind of work himself. We have had too many examples of times when there have been disagreements and jealousies. All of medicine will be strong-

er for having all of its practitioners pulling together, rather than criticising one another and impugning each others' motives as has sometimes happened. Private psychiatry can be of great assistance to both mental health and public health by serving on boards of these groups, helping on professional advisory committees and supporting mental health associations and public health associations that are working to establish and strengthen these programs. They can also promote legislation and appropriations on behalf of the public programs.

When all of medicine works together the concerned public is likely to listen and act, but when there is disagreement and apathy on the part of some of the profession the public is likely to balk. Let us keep an informed and united profession.

130 Sixth Street, NW

IMMUNIZATION CERTIFICATES ARE REQUIRED FOR SCHOOL ENTRANCE SAY HEALTH, EDUCATION OFFICIALS

An admissions crisis may be facing some Georgia elementary schools this fall, according to a joint statement by State School Superintendent, Dr. Jack P. Nix, and Dr. John H. Venable, director of the Georgia Department of Public Health.

"Approximately 50 per cent of the children who entered first grade in the fall of 1968—about 60,000 boys and girls—were admitted on provisional certificates of immunization, or no certificates," the statement says. "Under the Compulsory School Immunization Law, Act 1266 of the 1968 Georgia General Assembly, these children must have completed basic immunizations to protect them against six specific diseases—diphtheria, tetanus, whooping cough, measles, smallpox, and polio—as determined by State Board of Health ruling—if they are to be legally readmitted to the public schools this fall.

"The provisional certificates were issued for a period

of one year; they are not valid for the new school term," the state officials point out.

"In addition, all children coming into the school systems of the state for the first time—an estimated 125,000—must have completed these same immunizations and present certificates attesting to the fact," say Drs. Nix and Venable.

"It is imperative that parents understand that certificates of immunization are a requirement for school entrance just as are birth certificates," the statement continues. "The law was passed for the protection and well-being of our children. We must comply with its provisions.

"The immunizations required by the State Board of Health may be obtained through private physicians or local health departments who will then issue the appropriate certificates," the statement said.

HEALTH WORKERS TOLD OF NURSE SHORTAGE—ELECT NEW OFFICERS

In an allied meeting held in conjunction with the 40th annual meeting of the Georgia Public Health Association, a delegation of state nurses were told that Georgia needs 3,700 additional registered nurses today if the state is to meet the nationally recommended 300 registered nurses per 100,000 population.

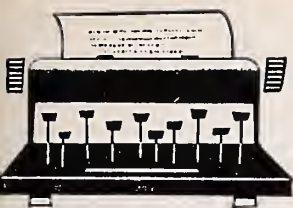
Mrs. Pat Malone of the Georgia Educational Improvement Council told the nursing group that the most critical need for more nurses is in the rural areas of the state. She pointed out that the larger metropolitan areas fall near the national recommendation, but a recent survey made by the council indicates that north Georgia has only 99 registered nurses per 100,000 population while middle Georgia has 147 per 100,000. The survey also shows that the southern

area of the state (excluding metropolitan areas) is somewhere between 99 and 147 nurses per 100,000 population.

Discouraging Outlook

Mrs. Malone said that the outlook for recruiting female high school graduates to attend nursing schools is not encouraging. She reported that 7 per cent of the graduating female teenagers entered nursing schools in 1950, but in 1966 less than 4 per cent chose nursing as a career.

"One of the major goals of our Council is to get qualified high school graduates to go into the nursing profession," Mrs. Malone said.



Changes in Medicaid

THE DEPARTMENT OF HEALTH, EDUCATION AND WELFARE on June 30, 1969 made an abrupt announcement of significant changes in the payment of physicians. The changes were published in the Federal Register on July 1, 1969 and became effective on that date. No opportunity was provided for a discussion of the changes before the date on which they became effective.

The changes may be summarized briefly as:

Freezing payments to physicians under Medicaid at rates not to exceed the levels paid on January 1, 1969.

The effective levels at which the payments are to be made is arrived at the 75th percentile of the charges by physicians.

No increase is to be permitted until July 1, 1970.

After July 1, 1970, the increases in payments to physicians will not be permitted to exceed the increase in the Consumer Price Index (adjusted to exclude the medical component) for the time interval involved.

It is unfortunate that HEW announced its policy changes in this fashion. The haste with which the regulations became effective did not permit a proper evaluation of the significant changes involved.

The patient is the primary concern for the physician. The new regulations now classify the indigent persons, by government decree, as second-rate patients. Payments to physicians under Title XVIII-B, Medicare, permit payments up to the 83rd percentile of physicians' charges. The new regulations restrict payments to physicians for the care of indigent patients under Title XIX, Medicaid, to the 75th percentile of physicians' charges. The medical profession seeks to provide indigent patients with first quality health care. It is regrettable that the new regulations of HEW designate the indigent person as a second-rate patient.

The immediate effect of the new regulations upon physicians' fees in Georgia may not be very great. The method of determining future increases in payments is far more important.

The proposed basis of the Consumer Price Index as the guide for increases in charges by physicians does not appear to be reasonable. The proposal would be reasonable if the increases in the cost of the other phases of the economy were also going to be controlled by the changes in the CPI. If the medical profession is to be the only segment of the economy to have its increases limited to the changes of the CPI, the regulation is not reasonable.

The Medical Association of Georgia would like to work cooperatively with HEW to improve the delivery of quality health care. Representative committees should be able to coordinate the delivery of health care more effectively than through the abrupt publication of regulations as has been done at this time.

John R. McCain, M.D.

Rural Health Conference Scheduled for September

THE FIFTH ANNUAL RURAL HEALTH CONFERENCE is scheduled for Wednesday and Thursday, September 10 and 11, at the Alpine Motor Lodge in Macon. Jointly sponsored by the MAG Committee on Rural Health and the Georgia Farm Bureau Federation, the 1969 edition is designed to inform registrants of some of the current problems facing rural Georgia and how many of these problems may be solved.

The keynote speaker will be Mr. Dale Clark, director of Public Affairs of WAGA-TV, Atlanta. Mr. Clark will discuss the need for more rural youth to enter the medical field.

Other areas of emphasis include: emergency highway care, traffic safety in the trucking industry, the role of the Medical College of Georgia in training family physicians, changing requirements in immunization, cardio-pulmonary resuscitation, dog control regulations, environmental pollution cause and cure, and conservation.

The 1969 program was drafted by the Georgia Rural Health Council, which is composed of representatives from the Georgia Congress of Parents and Teachers, Georgia Vocational Education, Georgia Safety Council, Georgia Department of Public Health, Georgia Farm Bureau, Georgia Extension Department, and the Medical Association of Georgia.

The two-day Conference will draw approximately 125 persons from all areas of Georgia representing both state and local rural organizations.

HEALTH BOARD REAFFIRMS NEED FOR NEW TB HOSPITAL

The need for a new state tuberculosis treatment hospital to replace Battey State Hospital in Rome was reaffirmed by the State Board of Health during its June meeting.

The action confirmed the Board's 1967 position that a new state tuberculosis control facility should be built in conjunction with a regional mental hospital for the northwest Georgia area. Plans call for construction of the dual-purpose hospital on the present Battey site. The facilities would share some administrative and maintenance services, but the patient care units would be separate.

Funds totalling \$100,000 were appropriated by the 1969 General Assembly for use in planning the new hospital as well as a regional mental hospital for the Columbus area.

Improvement in Techniques

The Board members earlier had heard a report from Battey Superintendent Dr. Raymond Corpe which indicated that while there had been a steady decline in the percentage of new cases of tuberculosis uncovered—nationally and in Georgia—that the total number of patients coming to Battey was remaining steady at

about 1,100 persons a year. "Improvement in treatment techniques and new drug discoveries have considerably shortened the average patient's stay at Battey," Dr. Corpe said. "Deaths in Georgia from tuberculosis now total about 80 a year," he added, "with most new cases coming from underprivileged urban areas."

Representatives from the Georgia Tuberculosis and Respiratory Disease Association, Dr. Ross L. McLean of Atlanta and Dr. Coleman King of Augusta, appeared before the Board to commend Battey's program and Dr. Corpe. Dr. McLean called the hospital, currently housed in aging former army hospital buildings, "a priceless asset for Georgia." A resolution of commendation from the Association was read into the minutes of the Health Board.

State Health Director Dr. John H. Venable reminded the Board members that "Battey is now the base for our total tuberculosis control program." Responsibility for the Health Department's statewide TB control activities was transferred to Battey in 1967. Previously, the control program had been directed from the Health Department's Atlanta office.

"The hospital is playing a much more important role now than ever before," Dr. Venable said.



ADDITIONAL DUES

THE ACTION OF THE 1969 HOUSE OF DELEGATES of the Medical Association of Georgia in amending the Bylaws of the Association to call for a dues increase for the year 1969 has brought forth a fair amount of comment, some favorable and some critical. It is felt that some remarks on the subject are in order, not as an apology, but as an explanation where one might be needed. First, let it be noted that this was the action of the House of Delegates, the largest and most representative body under our Constitution and Bylaws, not the action of a small group of officers or of an appointed committee. Article X of the Constitution says "Funds for the operation of the Association shall be raised by an equal per capita assessment on the members of each component society. The amount of assessment shall be set by the House of Delegates. . . ."

A special Ad Hoc Committee on Finance has been studying the financial needs of the Association for several years. In this committee's report to the House of Delegates in 1968, it noted that ten years before, in May, 1958, the dues had been raised to \$40.00 per year and had not been raised from that figure, despite rising costs and expanded activities by the Association and its Headquarters. At the same session, plans for expanding the Headquarters building were shown and the House was in favor of proceeding with the expansion. At that time, the Committee on Finance, the Special Committee on Finance and the Building Committee stressed the fact that we were facing the need of additional finances to meet additional costs. An increase in dues last year was strongly considered but put off until later. All these facts are a matter of record and can be found in the official publication of the Association, the *Journal of the Medical Association of Georgia*. Unfortunately, it is only through the pages of the *Journal* that the duly elected officers of the Association, the Council, the Executive Committee and last but by no means least, the House of Delegates can communicate with the membership, with no assurance that they are listening on the other end.

The relative advantages of calling this additional money to be raised "additional dues" versus "assessment" were considered thoroughly with the help of legal counsel, with the result that the unquestionably tax-deductible route of "additional dues" was carefully adopted. To those who had had no previous knowledge of the action of the House of Delegates and who were therefore "shook up" by the unheralded letter announcing the extra dues, my apologies; this was in order to allow for the maximum time for payment and therefore done before the June issue of the *Journal* with the actions of the House came out.

A look at the dues paid by physicians in our sister states may be of interest:

Alabama	\$ 70.00 per year
Florida	\$ 70.00 per year
South Carolina	\$ 75.00 per year
Tennessee	\$ 80.00 per year
North Carolina	\$155.00 per year (This includes \$65.00 per year for five years for building fund.)

PRESIDENT'S LETTER / Continued

In the light of these figures, our dues in Georgia of \$40.00 per year for the past ten years, when everything else has gone up, look like a bargain, and a tribute to those who have handled our finances so well, at the same time keeping our Association in the forefront of 50 state medical associations.



John Kirk Train, M.D.
President, Medical Association of Georgia

CALENDAR OF MEETINGS

In Georgia

Sept. 11-13—Eighth District American Society of Anesthesiologists Meeting, Atlanta.

In the Nation

Sept. 2-6—International Tuberculosis Conference, Waldorf Astoria Hotel, New York, N.Y.

Sept. 4-6—American Association of Obstetricians and Gynecologists, The Homestead, Hot Springs, Va.

Sept. 7-12—Second Conference on Experimental Medicine and Surgery in Primates, Hunter College-Bellevue Department of Nursing Education, New York, N.Y.

Sept. 11-16—Council on Occupational Health, Stouffer Riverfront Inn, St. Louis, Mo.

Sept. 14-16—Medical Progress Assembly, Parliament House, Birmingham, Ala.

Sept. 14-20—College of American Pathologists, Palmer House, Chicago, Ill.

Sept. 14-20—International Congress of Electroencephalography and Clinical Neurophysiology, El Cortez Hotel, San Diego, Calif.

Sept. 16-20—Congress of Neurological Surgeons, Sheraton-Boston Hotel, Boston, Mass.

Sept. 19-20—Conference on Stroke, Pick-Nicollet Hotel, Minneapolis, Minn.

Sept. 19-20—Council on Drugs, AMA Headquarters, Chicago, Ill.

Sept. 19-21—Council on Legislative Activities, Boston, Mass.

Sept. 21-25—International Symposium on Comparative Leukemia Research, Cherry Hill Inn, Cherry Hill, N.J.

Sept. 21-27—World Congress of Neurological Sciences, New York Hilton, New York, N.Y.

Sept. 26-Oct. 3—American Academy of General Practice, Philadelphia, Penn.

Sept. 29—Society for Pediatric Radiology, Washington Hilton Hotel, Washington, D.C.

Oct. 6-10—American College of Surgeons, Fairmont Hotel, San Francisco, Calif.

Oct. 8-11—National Hemophilia Foundation, Drake Hotel, Chicago, Ill.

Oct. 8-11—National Conference on Physicians and Schools, Pick-Congress Hotel, Chicago, Ill.

Oct. 11—GaMPAC Workshop, Royal Coach Inn, Atlanta, Ga.

Oct. 11-12—American Association of Ophthalmology, Palmer House, Chicago, Ill.

Oct. 12-17—American Academy of Ophthalmology and Otolaryngology, Palmer House, Chicago, Ill.

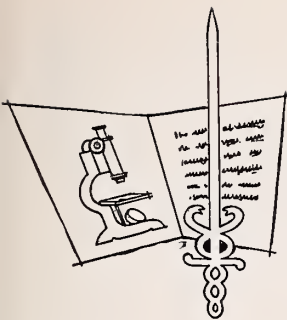
Oct. 12-16—American Society of Plastic and Reconstructive Surgeons, Chase-Park Plaza, St. Louis, Mo.

Oct. 18-23—American Academy of Pediatrics, Palmer House, Chicago, Ill.

Oct. 25-29—American Society of Anesthesiologists, San Francisco Hilton, San Francisco, Calif.

Oct. 29-Nov. 2—American College of Chest Physicians, Palmer House, Chicago, Ill.

Oct. 31-Nov. 3—Association of American Medical Colleges, Netherlands Hotel, Cincinnati, Ohio.



REACH TO RECOVERY

C. RIDLEY WHITE, M.D., F.A.C.S.,* *Macon*

THE AMERICAN CANCER SOCIETY, through the years, has and does offer many services to cancer victims which also aid the medical profession. In September, the Georgia Division of the A.C.S. will offer a rehabilitation program known as Reach to Recovery, for mastectomy patients, designed to meet their psychological, physical and cosmetic needs.

The Reach to Recovery Program of the American Cancer Society was originally founded by Mrs. Terese Lasser of New York in 1953 as The Reach to Recovery Foundation, a non-profit organization. On February 5, 1969 this program became part of the American Cancer Society's Voluntary Patient Service with Mrs. Lasser serving as consultant.

This program enables the physician and surgeon to provide mastectomy patients with specialized assistance without cost and without interfering with the doctor-patient relationship. Medical personnel are also relieved of many time-consuming activities which are not primarily medical in nature but are most important to the total recovery of the patient. The mastectomy patient is able to see and talk to another woman who has had the same surgery. She sees living, visual proof that it will be possible for her to look normal and to assume her normal activities. She receives practical help on how to go about doing it.

High Standards

The Reach to Recovery Program has established high standards for the program and requires strict adherence to its procedures by all volunteers working with patients. The hospital volunteer program is carried out only with the knowledge and consent of a physician or surgeon, and at no time is a patient visited in the hospital unless such consent has been obtained. Only a woman who has herself undergone a mastectomy may work with patients. In addition a doctor must certify that she is physically and emotionally equipped to participate in the program. The volunteer, once approved, is thoroughly trained in procedures for visiting patients, and particularly in what not to say. The importance of her whole manner and appearance is stressed in her training.

Upon visiting a patient, the volunteer provides a gift of a Reach to Recovery Kit. The kit contains a Reach to Recovery manual (information for the patient and her family), a ball and rope for exercises, and a temporary prosthesis for the patient to wear when leaving the hospital. The volunteer gives information on exercises, suggestions for brassiere comfort and clothing adjustments, and explana-

* Division Medical Advisor, A.C.S., Reach to Recovery Program.

tions of the various prostheses. She also answers questions the patient may have of a non-medical nature. Volunteers never make comparisons or answer medical questions. They do recommend that the patient discuss matters with her own physician.

Prosthesis Information

When the patient is told by her doctor that she is ready to be fitted with a regular prosthesis, she may visit the Reach to Recovery office for further information on the various types of forms available and where they may be purchased. Patients are also given assistance on special clothing problems, particularly bathing suits. Nothing is ever sold to a patient, no products are ever sponsored, and patient names are kept confidential.

Reach to Recovery is not a club and a woman is encouraged to return to her normal way of life as soon as possible. Mastectomy patients are offered no morale-destroying pity or sympathy. They are offered living proof and assurance that they are just as much a woman, just as much a person, as they ever were. This, plus the practical assistance provided, helps in getting a woman back to the important things in living.

While the benefits to the patient are the prime asset of this program, the advantages of the service for the surgeon and physician should not be overlooked. The demands and pressures on every member of the medical profession and his staff continue to increase. Here is a service which the physician may make available to his patient without cost and without interfering with the doctor-patient relationship.

I urge all physicians in Georgia to avail themselves and their mastectomy patients of the services of Reach to Recovery. Inquiries and arrangements for services of this program will be directed to the American Cancer Society, Georgia Division—or to the local unit office where referrals to the Regional or Unit Coordinator will be made.

763 Pine Street

CONFERENCE ON STROKE SCHEDULED FOR SEPTEMBER

A conference sponsored by The American Rehabilitation Foundation under a grant from Social and Rehabilitation Services, U.S. Department of Health, Education, and Welfare, reports the results of a four-year research project conducted at the Kenny Rehabilitation Institute entitled "Rehabilitative Predictors in Completed Stroke." Twenty-five national leaders in fields of rehabilitation medicine, neurology, speech, and related specialties will serve as panelists and speakers, reflecting the multi-disciplinary nature of the

research project. Sessions include measurements of improvement in completed stroke, rehabilitative predictors in completed stroke, environmental correlates of differential outcomes, and implications for future research. The conference will be held September 19-20, Pick-Nicollet Hotel, Minneapolis, Minn. Fee: \$20; registration open to all disciplines. For further information, contact: Dr. Thomas P. Anderson, American Rehabilitation Foundation, 1800 Chicago Avenue, Minneapolis, Minn. 55404.



CONTROL OF HYPERLIPIDEMIAS

J. GORDON BARROW, M.D., *Atlanta*

AS HAS BEEN POINTED OUT in Dr. Garrison's previous Heart Page, it is now possible for us to identify those in the population at high risk for premature coronary disease. One of the major risk factors is hyperlipidemia. For many years it was the practice of most physicians to evaluate the serum cholesterol of patients and to make the decisions as to whether or not the patient should be treated on the serum cholesterol level alone. We know now that serum cholesterol is only one of the lipid fractions and that hyperlipidemia may be manifested by elevated triglyceride, elevated cholesterol, abnormal serum lipoprotein electrophoretic patterns, or various combinations of the three.

It is well for the physician to remember that serum cholesterol levels are not influenced by eating a meal; therefore, the specimen may be obtained at any time. However, triglycerides are extremely sensitive to a previous meal and must always be obtained when the patient is fasting. It is usually not necessary to use the entire lipoprotein package in screening the population or in initial studies of patients in the physician's office. It is sufficient to draw a fasting serum, do a serum cholesterol on this, and let the remainder of the serum sit overnight in the refrigerator. If it remains clear, the triglyceride is almost certainly normal. If, then, the cholesterol value is well within the normal range, there is no reason to go any further into the investigation of this particular patient. However, if the cholesterol is elevated, or if the serum is turbid, or if a cream layer rises to the top of the serum, it is extremely important that a triglyceride and electrophoretic pattern be obtained in order to identify which of the five types of hyperlipidemia may exist in this patient.

Age Factor

It is well to remember that the levels usually quoted by most laboratories as being normal for serum cholesterol are not normal values but average values for adult Americans. I personally consider a level of 180 milligrams per cent (plus or minus 10) to be normal around the age of 20, gradually rising to 220 milligrams per cent (plus or minus 10) at age 60 and decreasing slowly thereafter. It is, therefore, important to consider the patient's age when deciding whether his cholesterol level is normal or abnormal. If the cholesterol is abnormal, or if the serum is turbid, I would refer the reader to Dr. Donald Fredrickson's recent articles (New Eng. J. Med. 276:34-44, 94-103, 148-156, 215-226, 273-281—Jan. & Feb. 1967) on the five major categories of primary hyperlipidemia so that a definitive diagnosis of type can be made.

Prepared at the request of the Committee on Professional Education of the Georgia Heart Association. Dr. Barrow is Clinical Professor of Medicine at Emory University School of Medicine, Atlanta, and Director, Georgia Regional Medical Program.

This is particularly important in view of the fact that dietary management of the five types is greatly different. In the treatment of Type I, moderate restriction of dietary fat (20 to 25 grams of fat per day) seems to be sufficient, and the saturation of the fatty acids in the diet seems to make little or no difference. In Type II, a low-fat diet containing no more than 20 to 25 grams of saturated fat per day and less than 100 milligrams of cholesterol is important. Polyunsaturated fats may be added to make the total fat intake 30 to 40 per cent of calories if desired. In Type III, weight reduction is apparently the key factor. In these patients the weight must always be controlled if the lipids are to be controlled, and we should aim for 10 per cent less than normal weight if this can be achieved. Actually, diets containing 40 to 50 per cent of calories from fats are satisfactory if the total number of calories is kept low and the fat calories are high in polyunsaturated fats and low in cholesterol. In Type IV, carbohydrate induction should be tested since most of these patients will respond abnormally to excessive carbohydrate intake. In most of these patients, it is necessary to markedly reduce carbohydrate in the diet to give 45 to 50 per cent of calories from fats, particularly the unsaturated low-cholesterol types. Sugars and simple starches should be avoided wherever possible. In Type V, weight maintenance at the normal or slightly below normal level appears to be very important. It also appears to be important to give a relatively balanced diet, not unusually high in either fats or carbohydrates.

Varied Approach

It may, therefore, be seen that we vary in our approach from a low fat, high carbohydrate diet to a low carbohydrate, high fat diet and that it is absolutely impossible to determine which of these approaches should be taken in the individual patient without a study of the electrophoretic type of hyperlipidemia. These therapeutic diets will produce modest but definite decreases in the elevated lipids. Although it has not been conclusively demonstrated that these changes are accompanied by a decreased incidence in atherosclerosis and its complications, there is some evidence to suggest that this occurs.

The place of drugs in the hyperlipidemias is not yet fully understood. Drugs seem to have no place in the treatment of Type I. In Type II, all of the drugs which have been used in hypercholesterolemia have been successful in some degree in lowering the lipid levels; Cholestyramine, B-sitosterol, D-thyroxine, Nicotinic acid, Chlorophenoxyisobutyric acid (CPIB) and the estrogenic hormones have all had success claimed for them at one time or another in this type. In Type III, CPIB may be the most effective drug. In Type IV, orally administered anti-diabetic agents may be of value, particularly if the response to carbohydrate loading is impaired. CPIB and Nicotinic acid are probably the other two most effective drugs. Type V has not been well enough studied to be certain which of the drugs may be effective in its treatment.

938 Peachtree St., N.E.

GaMPAC WORKSHOP

Royal Coach Inn, Atlanta
(I-75 at Howell Mill Rd., N.W.)

OCTOBER 11, 1969

All Physicians & Wives Invited



“TRUTH IN LENDING”

HEWITT H. COVINGTON, *Atlanta**

ON JULY 1, 1969, the Federal law on Truth In Lending became effective. This is the major portion of the Consumer Credit Protection Act signed into law on May 29, 1968. This legislation requires creditors to inform those of their customers who are natural persons obtaining credit for personal, family, or household purposes, of all the direct and indirect costs, terms, and conditions of the credit arrangement. There are criminal and civil penalties against creditors who fail to comply.

Credit arrangements of nearly all forms—where made for the personal family or household purposes—are subject to the requirements of the law. It is, therefore, beyond the scope of this article to attempt to give more than a general outline of the features of the law, coupled with the usual admonition that in these articles we cannot attempt to give legal advice. Each reader must consult his own legal adviser on the basis of the specific facts peculiar to his own situation.

Such a general outline can best be presented by use of the definitions pertinent to the law. These definitions are contained in the governing regulation, called Regulation Z, promulgated by the Federal Reserve Board under the authority and direction of the Act itself. The Federal Reserve Board is charged with the overall interpretation and effect of the law, but enforcement of the law and Regulation Z is divided among nine different Federal agencies according to classes of creditors. Enforcement with relation to physicians as creditors is with the Federal Trade Commission. Contact or consultation with the local or Washington office of that agency as well as the physicians' own legal advisers should be had on specific questions or matters.

Some of the pertinent definitions against which to measure the physicians' own involvement and responsibilities follow.

Compliance Required

As a starting point, compliance is required of a “creditor.” A creditor is defined to mean any person who, in the ordinary course of business, regularly extends or arranges for the extension of “consumer credit.” Credit is the granting of a right to defer payment of a debt. It seems to this writer that the physician who steadfastly refuses to defer payment at all and takes only cash need read no further. However, the great majority of physicians who do allow terms to some patients probably do so “in the ordinary course of business regularly” within the meaning of the statute.

*Prepared at the request of The Medical Association of Georgia. Mr. Covington is a member of the firm of Alston, Miller & Gaines, General Counsel to The Medical Association of Georgia.

If the physician does extend credit in the ordinary course of his business, it seems almost certain that the next criterion is also met. The physician's services are peculiarly for personal, family, or household purposes as required by the statute. The only exception would be the industrial practice of a physician who is paid by an employer to perform services for his employees. It is probable that the industrial practice does not involve the extension of credit to such employers in any event. However, the relationship with such an employer would not be subject to the Truth In Lending legislation.

The Act only applies if "consumer credit" is involved. Apparently the Act covers any charge for the credit (e.g. interest, time payment, carrying or service charge—called FINANCE CHARGE under the law). It also covers any arrangement where repayment is to be made, under an agreement (written or oral) in more than four installments whether or not any charge for the credit is made.

Therefore, any physician who has a regular practice of permitting patients to defer payment of fees should discuss the provisions of the Act with his attorney. It appears to this writer that "on account" deferred billing arrangements may not be subject to the Act if no finance charge is made and if the physician does not charge the "on account" patient more for the same services than he would charge a cash patient.

Requires Statements

If the physician is subject to the Act, then the Act requires certain statements to be prepared and given to the patient. If the physician has an open account revolving credit arrangement with the patient and makes a finance charge, a statement should have been prepared and mailed to the patient by July 31, 1969. In addition, Regulation Z also prescribes the exact terms that must be used in making disclosures on every monthly billing to such patient. Regulation Z specifies where the terms are to be placed on the billing and the size of type which certain terms must have.

It is most important to observe that where the open end credit is under a credit card or other charge account arrangement or program, it is the creditor who issues the card or whose program it is who is responsible for a compliance with the Act. For instance, if a physician uses a bank credit card or medical payment plan or similar open end credit plan, the bank or other business is the creditor and the physician member of the plan is not charged with compliance with Truth In Lending as to that plan. The physician is only charged with compliance with the Act with his own extension of credit to his patients. This will include the making by the physician of an extra or increased charge where a bank credit card plan is used.

Failure to comply with the Act can result in a fine to be paid by the creditor of not more than \$5,000 or imprisonment of the creditor for not more than one year, or both. Failure to make the required disclosures to any person makes the creditor liable to the debtor for twice the amount of the finance charge, but not less than \$100 nor more than \$1,000 together with the costs of the action and reasonable attorneys' fees.

Two examples seem most likely to be the practice involved by physicians in Georgia. Suppose that Dr. Surgeon discusses a serious operation with Mrs. Patient and tells her that his normal fee for the particular procedure would be \$500. Mrs. Patient says that she cannot pay that amount at one time but could pay \$100 a month for five months. Dr. Surgeon replies that that would be fine and if she pays \$100 a month for five months he will be paid in full. Even though Dr. Surgeon has not charged Mrs. Patient any interest or finance charge, he must give Mrs. Patient a written statement at the time of making the arrangements with her. Arrangements existing on the effective date of the Act on July 1, 1969, similar to the arrangement between Dr. Surgeon and Mrs. Patient, do not require any written

statement to be sent by the physician to the patient. However, any new arrangement on and after July 1, 1969, if payment of the physician's charge is to be made over more than four installments, will be subject to the Act even if no interest or finance charge is proposed.

Disclosures Not Required

Mr. Employee, married with five children, earns \$500 a month. He lives in a small community in Georgia and discusses the medical needs of his family with Dr. Physician, a prominent general practitioner of the town. Mr. Employee tells Dr. Physician that he knows from time to time the medical requirements of his family may, in a particular month, exceed his capacity to pay. However, he intends to see that Dr. Physician is properly paid. Dr. Physician says to Mr. Employee, "I do not mind your taking a little time to pay me provided you pay something regularly each month." They agree that \$25 a month would be an appropriate amount whenever Dr. Physician's charges get above that amount. Dr. Physician is very careful always to charge Mr. Employee his usual and customary charges for all services rendered to the Employee family. Dr. Physician charges no interest to Mr. Employee and makes no finance charge. While the issue may be debatable, this writer believes that Dr. Physician has no requirements to make any disclosures under the Truth In Lending Act to Mr. Employee. However, Dr. Physician could become subject to the Act and have to make required disclosures if he makes any finance charge at all, if he charges more than his usual and customary fees because he realizes that Mr. Employee will be slow in paying, or if he notes on his billing statement that Mr. Employee may have a 2 per cent discount if he pays sooner than the arrangement on which they had agreed. Further, should Dr. Physician require of Mr. Employee that he secure the arrangement by a mortgage on his personal residence, other special provisions of the Truth In Lending legislation would apply.

Compliance with the statute is quite complicated. For example, the one-time extension of credit in more than four installments, according to Regulation Z, calls for 15 specific disclosures. Integral to all of the disclosures is a statement, expressed in "simple interest percentages" of the effective rate of interest involved in the finance charge. The mathematics can be quite difficult.

In conclusion, let us reemphasize that we have only given a general outline of the matters involved in Truth In Lending. The many technical features and applications of the law could not be covered here and, if covered, we fear would be too tedious for the busy physician to plow through. Each "creditor" must compare the facts of his own methods and credit arrangements with the broad areas of coverage mentioned in this article. Hopefully, this article will supply enough information so that physicians who do extend credit will discuss the matter with their own attorneys. If coverage is involved, detailed technical compliance must be accomplished, again with the assistance of the physician's own attorneys.

*Suite 1220
C & S Bank Building*

CRIMINAL PROSECUTION OF HOMOSEXUALS

America's doctors overwhelmingly favor the removal of the criminal mantle from homosexuals. This finding is based on a survey of 2,257 doctors across the nation. The survey is sponsored by the Ortho Pharmaceutical Corporation of Raritan, N.J. Of physicians polled, 73 per cent said yes, 20 per cent said no, and 7 per cent did not answer when asked: "Do you approve of the elimination last year from the

criminal law in Great Britain of prosecution for private homosexual acts between consenting adults?" On the question, "Do you believe that if homosexuality is removed from a criminal law context it may aid in continued efforts to understand and to counsel patients who are homosexual?" physicians answered as follows: yes, 67 per cent; no, 25 per cent; no answer, 8 per cent.

THE ASSOCIATION



NEW MEMBERS

Browne, Rodney M., M.D.	740 Hemlock Street
Active—Bibb—OBG	Macon, Georgia 31201
Carr, Richard D., M.D.	80 Butler Street, S.E.
Active—Fulton—PM	Atlanta, Georgia 30303
Frank, Martin J., M.D.	Medical College of Georgia
Active—Richmond—I	Augusta, Georgia 30902
Harrison, Eugene O., M.D.	401 Peachtree Street, N.E.
Active—Fulton—SU	Atlanta, Georgia 30308
Keuls, Hans A., M.D.	1102 E. Lamar St.
Active—Muscogee—OBG	Americus, Georgia 31709
McLane, John E., M.D.	340 Boulevard, N.E.
Active—Fulton—OBG	Atlanta, Georgia 30312
Rowley, Charles M., M.D.	740 Hemlock Street
Active—Bibb—N	Macon, Georgia 31201

PERSONALS

Fourth District

The Locust Grove Home Makers Club honored **R. V. Brandon**, residing physician of the Westbury Nursing Homes of Jenkinsburg and Conyers, at their June meeting. Dr. Brandon received a plaque for his service to others.

J. R. Sams of Covington was honored on his 80th birthday by the Kiwanis Club of Newton County, for his 50 years of service to that county.

Dr. and Mrs. John M. Schreeder have been named "man and woman of the year" by the North DeKalb Exchange Club for years of outstanding service to their community.

Fifth District

Sheldon B. Cohen, Atlanta psychiatrist, presented a "Case Seminar in Forensic Psychiatry" at the Lenwood Division, VA Hospital in June.

Addison McGuire Duval, director of the Division of Mental Health of the Georgia Department of Public Health, spoke at the monthly meeting of the Dougherty County Medical Society in May.

Robert E. Wells, Atlanta orthopaedic surgeon, was chairman of a committee of Emory University physicians and other health authorities directing a three-day course on "Advanced Emergency Care of the Sick and Injured," held in June at Georgia State College.

Seventh District

Richard A. Griffin III was honored in May by the Cartersville Jaycees for his efforts to save the life of a Macon man injured in an automobile accident.

Richard Lee Hammonds of Austell has been re-elected to active membership in the American Academy of General Practice.

William E. Holladay of Marietta has been elected a Fellow of the American College of Physicians by the American Board of Internal Medicine.

Don W. Schmidt has been named Man of the Year for 1969 by the Cedartown Chamber of Commerce.

Tenth District

Robert R. McKnight and **Charles Freeman, Jr.**, spent two weeks in June on a tour of orthopedic hospitals behind the Iron Curtain. The tour group of 168 persons attended seminars and visited hospitals in Moscow, Leningrad and Puskin, Russia, as well as cities in Rumania and Budapest.

SOCIETIES

The **DeKalb County Medical Society** is sponsoring a new Explorer Medical Post, to acquaint youths 14 to 18 years of age with the whole field of medicine and what it offers to young people thinking of their professional future. The Post is being developed under the new contemporary Explorer program of the Boy Scouts of America.

Grady L. Hallman, associate professor of surgery at Baylor University, spoke on "Transplantation of the Heart" at the June meeting of the **Fulton County Medical Society**.

The **Glynn County Medical Society** voted in June to contribute \$1,000 to the Coronary Care Unit Fund of the Glynn-Brunswick Memorial Hospital.

The **Upson County Medical Society** has pledged \$10,000 in sponsorship of the intensive care and coronary unit of the Upson County Hospital expansion.

DOCTORS FAVOR LIBERALIZATION OF ABORTION LAWS

Of 2,257 physicians across the nation responding to an ORTHO PANEL survey on their feelings about the need to liberalize abortion laws, 91 per cent favor allowing abortions when the life of the mother is at stake; 86 per cent favor allowing abortions when the mother's health—physical or mental—may be permanently impaired; 81 per cent favor abortions if the pregnancy is likely to produce a permanently deformed or mentally retarded child; and 86 per cent favor abortion when pregnancy is the result of rape or incest.—Ortho Pharmaceutical Corp. Survey

GEORGIA PHYSICIAN ELECTED AMA VICE-SPEAKER



J. Frank Walker, M.D., Atlanta, past speaker of the MAG House of Delegates and current President of the Fulton County Medical Society, was elected to the position of Vice-Speaker of the AMA House of Delegates during its Annual Convention in New York City in July.

Dr. Walker, President of the American College of Radiology, has been a member of the 244-member AMA House of Delegates since 1962.

Elected by the House from a four-man field that included candidates from the populous areas of New England, California and the Middle West, Dr. Walker scored an overwhelming second ballot victory to become the first elected AMA official from Georgia since Dr. Eustace Allen held the post of Vice-President in 1961-62.

Announcement of Dr. Walker's victory on the final day of the Convention climaxed an intensive campaign in which all members of the MAG Delegation to the AMA House participated vigorously, and was greeted by an enthusiastic round of applause from the House.

Dr. Walker's name was placed in nomination by Dr. F. William Dowda, Atlanta, standing in for senior MAG Delegate, Dr. J. W. Chambers of LaGrange who was unable to attend by reason of illness.

The *MAG Journal* would like to extend its hearty congratulations to Dr. Walker and to his fellow Delegates and Alternate Delegates from Georgia.

HEART ASSOCIATION SETS DEADLINES FOR SUPPORT APPLICATIONS

Research investigators may now apply to the American Heart Association for support of studies to be conducted during the fiscal year beginning July 1, 1970.

September 15, 1969, is the deadline for submitting applications for Established Investigatorships, British-American Research Fellowships and foreign Visiting Scientist Awards. Applications for Grants-in-Aid are due no later than November 1, 1969.

Awards in 1970-71 will be made as follows:

Established Investigatorships—Five-year awards to scientists of proven ability who have developed their careers to the point where they are able to conduct independent research. Stipends begin at \$13,000 with fringe benefits and \$1,000 yearly increments. An additional \$1,000 is given annually as a departmental grant to the investigator's department head.

British-American Research Fellowships—One-year training awards to U.S. citizens, usually with two years of postdoctoral research experience at time of application, to work in a qualified institution in Great Britain. Stipend \$7,500 plus dependency and travel al-

lowances. Departmental grant, \$750.

Visiting Scientists—Awarded for three to 12 month periods, enabling American investigators to invite experienced foreign scientists to the U.S. for research collaboration. Stipend negotiable per comparable positions at host institution, and travel allowance. Application must be initiated by U.S. host scientist. Although the primary deadline is September 15, additional applications will be received until December 31, 1969, subject to the availability of funds.

The Association also appoints a limited number of investigators of unusual capability and widely recognized accomplishment as Career Investigators, assuring them of financial support throughout their careers. Career Investigatorship awards are made by the AHA Board of Directors on recommendation of the national Research Committee, and *not by application*.

Application forms for investigatorships, fellowships, and grants may be obtained from the Research Department, American Heart Association, 44 East 23rd Street, New York, N.Y. 10010.—Georgia Heart Association, Inc.

THE MONTH IN WASHINGTON

The Internal Revenue Service plans to audit the federal income tax returns of physicians and other health practitioners who have received more than \$25,000 a year in medicare and medicaid payments.

Plans for the special audit were disclosed by IRS Commissioner Randolph W. Thrower at the first of a series of public hearings the Senate Finance Committee is holding in its investigation of the rising costs of the two government health care programs. He said the Department of Health, Education and Welfare had agreed to require intermediary insurance carriers to use physicians' social security numbers on reports of payments under the program in the future.

Finance Committee Chairman Russell B. Long (D., La.) estimated "possibly as many as 10,000" had been getting upwards of \$25,000 a year under the programs. Thrower said the initial audits would be for 1967 and would be limited to those receiving more than \$50,000.

Widespread Abuse

Long said that the investigation of the committee's staff so far showed "widespread abuse, and fraud, as well as lax administration."

Robert M. Ball, social security administrator, reported his investigators had looked into more than 700 possible fraud cases under medicare. He said more than 300 of these cases were still in some stage of inquiry, and that 14 had been turned over to the Justice Department for prosecution.

"But these should not be taken as a reflection on the 200,000 doctors participating in medicare," Ball said. He added a bigger problem than outright fraud were "cases that don't quite become fraud."

Wants Authority

HEW Undersecretary John G. Veneman told the committee that the Nixon Administration wants congressional authority to stop medicare payments to doctors who overcharge, use inferior supplies or engage in fraud.

"Under present medicare law, there is no authority for the program to deny reimbursement to a licensed practitioner who has demonstrated a clear pattern of fraud, repeated overcharging of the program or the use of supplies which are inferior or harmful," Veneman said.

"We are recommending authority . . . to discontinue future reimbursement and to put all parties on notice to this effect where on the basis of clear evidence, a finding is made that this is justified by reason of such abuses."

Not Overcharging

Commenting on the hearings, Dwight L. Wilbur, M.D., president of the American Medical Association, said that the vast majority of physicians serving medicaid patients are not overcharging for their services.

"Most physicians," Dr. Wilbur said, "are acting honorably and with utmost restraint. Fortunately, very few M.D.'s participating in medicaid are guilty of overcharging and otherwise exploiting the program.

Such exploitation by a minuscule minority was unavoidable. . . .

". . . The medical profession is making a great effort to identify and weed out dishonest doctors who betray their oath as professional men serving the public. We have been successful in this search, but a few physicians remain who still are not identified. We shall search them out and expose them, for the good of the entire profession."

Fee Limitation

Meantime, HEW issued a regulation limiting the fees paid by states to physicians, dentists and other health practitioners under medicaid.

Under the regulation, a state's medicaid payment to a physician for a service will be limited, with one exception, to the 75th percentile of the customary charge—the maximum customary fee of 75 per cent of the physicians in the area.

If a state has been paying more than the 75th percentile of the customary charge, it must not exceed the medicare level, about the 83rd percentile. A medicaid official said that only two states may have to roll back their fees, but declined to name them.

May Request Increase

After July 1, 1970, states may request permission to increase physicians' fees above the 75th percentile if two conditions are met:

1. The average percentage increase requested above the 75th percentile on January 1, 1969, may not exceed the percentage increase in the all-services com-

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ponent of the Consumer Price Index (adjusted to exclude the medical component) or in an alternate index designated by the Secretary of Health, Education and Welfare.

2. Evidence must be clear that the providers and the states have cooperatively established effective utilization review and quality control systems.

Other Requirements

The new fee regulation also requires states to revise their medicaid plans to include descriptions and details of their payment structures. A state that wishes to revise its payment structure for practitioners' services or change the payments authorized under it may not do so until the proposed changes have been approved by the Secretary of Health, Education and Welfare or his representative.

States that begin their medicaid programs after July 1, 1969, must arrange their payment structures so that fees do not exceed the 75th percentile of customary charges.

HEW estimated the regulation would result in a saving of \$65 million in the first year.

Discontinued Allowance

Despite a strong protest by the American Hospital Association, HEW discontinued the overhead medicare-medicaid percentage allowance paid to hospitals, extended care facilities and other institutional providers. It was two per cent for non-profit and one-

and-one-half per cent for proprietary institutions. The action was effective July 1, 1969.

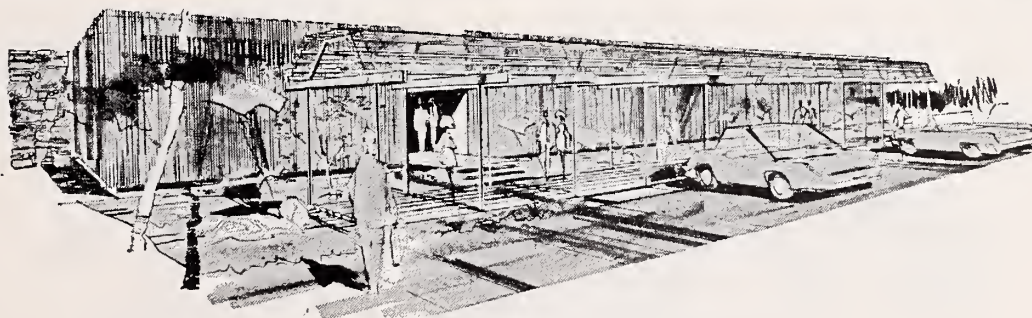
Another new medicaid regulation requires states to provide periodic health screening, diagnosis, and treatment for all eligible youths under 21 years of age, effective July 1, 1969.

HEW also established a new classification of institution—called intermediate care facility—eligible to receive federal contributions for the care of aged, blind, or disabled recipients or public assistance as covered in another regulation. This should reduce costs of medicaid by allowing states to relocate substantial numbers of welfare recipients who are now in skilled nursing homes in lower cost institutions, HEW said.

New Assistant Secretary

Dr. Roger O. Egeberg, who has been dean of the School of Medicine, University of Southern California since 1964, was selected to be the new Assistant Secretary of Health, Education and Welfare for Health and Scientific Affairs after a five-month delay.

President Nixon nominated Dr. Egeberg after HEW Secretary Robert H. Finch "reluctantly and regretfully" withdrew his unannounced but widely-publicized selection of Dr. John H. Knowles, director of Massachusetts General Hospital, Boston. Finch said that "the protracted and distorted discussion" about the appointment during the five months the post had been vacant "resulted in a situation in which he (Knowles) would not be able to function effectively in this critical position."



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WASHINGTON / Continued

The news media—press, radio and television—generally assigned the opposition to Dr. Knowles to conservative members of Congress, led by Senate Republican Leader Everett M. Dirksen, and to the AMA.

AMA Statement

Throughout the public controversy before the appointment, the AMA confirmed its comment to a short statement that it had suggested several names to Finch for the post and that the Association “favored the appointment of someone who would represent the broadest scope of medicine and would not be too closely oriented to any one segment of medicine or the health field.” Knowles was not one of the physicians on the AMA list.

A few days after the nomination of Dr. Egeberg, Dr. Dwight L. Wilbur, the AMA President, said:

“During the last five months the American Medical Association has been identified repeatedly as a force opposing appointment of Dr. John H. Knowles as Assistant HEW Secretary for Health and Scientific Affairs.

“We held our silence during the last months of nationwide publicity because we agreed with Secretary Finch to make our suggestions to him and then say no more. We did that. The Knowles protagonists obviously did just the opposite. . . .

“In a true sense, we never opposed Dr. Knowles. But we did not support him because we had alternative recommendations.”

Recommended by AMA

Those recommended by AMA for the position, Dr. Wilbur said, included:

—Dr. W. Clarke Wescoe, former Chancellor of the University of Kansas, “who withdrew soon after because of personal reasons.”

—Dr. Richard S. Wilbur, Palo Alto Clinic, Chairman of the Council of the California Medical Association, and former Chairman of the Board of California Blue Shield, “who happens to be my nephew, a fact which complicated the situation, but who AMA felt was a well-qualified man for this position.”

—Dr. John R. Hogness, Dean of the University of Washington School of Medicine, “who serves in the AMA House of Delegates, at high level in the Association of American Medical Colleges, and who has many other distinguished achievements.”

Commended Selection

The AMA commended the selection of Dr. Egeberg. In a telegram to Finch, Dr. Wilbur said:

“We look forward to a productive relationship with you and Dr. Egeberg in advancing the health care system for the benefit of all the American people. There are many complex factors involved that will call for the wholehearted dedication and contribution of all in the medical profession and in government.”

“We believe Dr. Egeberg will be able to bring about the necessary close coordination between government and private sectors in the health care system,” Dr. Wilbur said in a supplementary statement. “This is vital to constantly advance and expand the ability to provide quality health care for all Americans.”

Moderate Liberal

Dr. Egeberg, 65, is a large, bluff man of Norwegian stock who demonstrated a sense of humor at his first news conference. He is a member of the AMA and a diplomate of the American Board of Internal Medicine. Generally considered a moderate liberal on health matters, he served on several advisory commissions during the Kennedy and Johnson Administration and on the state level in California. One of his major interests has been health care of the poor and he arranged for the USC medical school to be the medical consultant for the neighborhood health center in the Watts district of Los Angeles.

At his first news conference in HEW, he classified delivery of health care as almost the department's number one problem. He said medicare now is “rather well established” in solving a problem. But medicaid, he said, “has run afoul of a number of things, and I don't know that one can blame any one person or any group for this.”

A member of the Army Medical Corps in World War II, he was personal physician and aide-de-camp to General of the Army Douglas MacArthur, 1944-45.

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WANTED: General Practitioner to associate with three-man group in middle Georgia community. Approved hospital. Excellent opportunities. Reply to Box 117, c/o JMAG, 938 Peachtree Street, N.E., Atlanta, Ga. 30309.



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REPORT OF PROGRESS ON NEW BUILDING

In order to keep MAG members abreast of the progress on the new building, here is a pictorial report of the construction now going on.

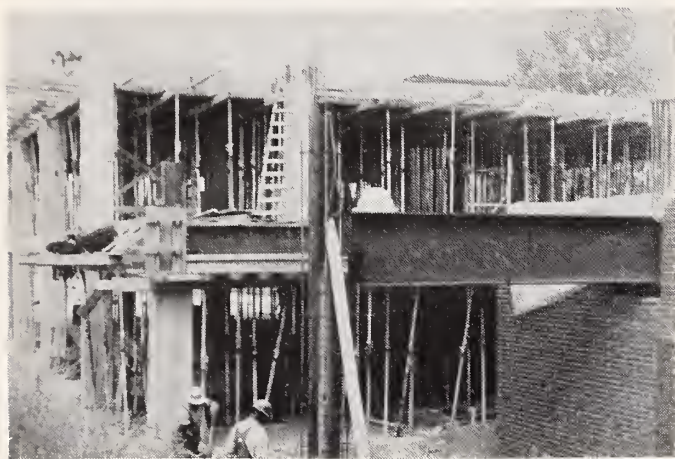


Fig. 1: This view from Peachtree Street shows placement of a steel beam to compensate for the columns eliminated by the driveway.



Fig. 2: This Southern exposure will be faced with cast stone.

POSTGRADUATE COURSE IN ENT

The University of Miami School of Medicine, Division of Otolaryngology, is presenting a postgraduate course in ENT for the Family Practitioner. The course will be held November 7-8, 1969, in Miami Beach, Florida. Course Director:

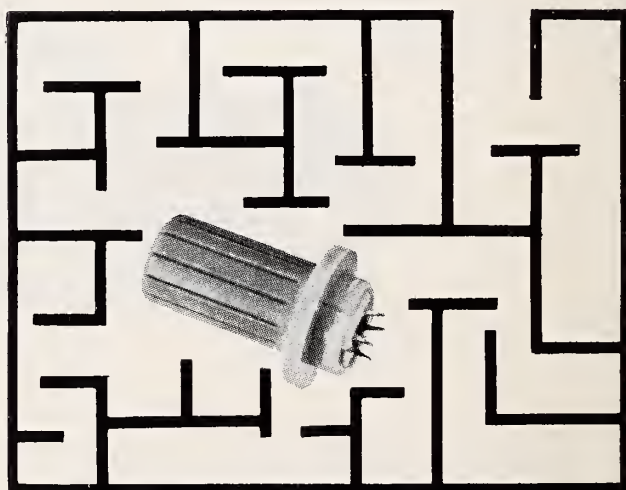
Fredric W. Pullen, II, M.D.
University of Miami School of Medicine
Division of Otolaryngology
P.O. Box 875, Biscayne Annex
Miami, Florida 33152



Fig. 3: A rear (West) view, showing part of the top parking deck.

TO ABORT OR NOT TO ABORT

"The need for revision of the abortion laws can be no more dramatically illustrated than by realizing that in California, doctors were brought before medical examiners for having performed abortions on women with German measles, and in New Jersey, doctors were taken to court for not having done abortions in the same type of case." (Robert E. Hall, M.D., Columbia University, in ORTHO PANEL 4, published for physicians by the Ortho Pharmaceutical Corporation, Raritan, N.J.)



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SUBURBIA—DANGERLAND USA

Lawn mowers chug, chug, chugging across centipede, zoysia, bermuda and fescue covered yards. Bicycles and motor bikes zipping up and down quiet residential streets. Children laughing, shouting, running after puppies and balls. There is a pleasant sameness about weekend suburbia at work and play. It's where the family action is. It's an environment filled with the potential for tragedy as well.

Many of these tragedies are caused by power mowers. They involve the loss of fingers and toes, and of eyes. They sometimes result in permanent disabilities that cripple and maim victims for life.

Although a check of four Atlanta area hospitals—South Fulton, Grady, Kennestone and DeKalb General—failed to come up with an accurate count of mower injuries, hospital personnel say they have increased in recent weeks. According to emergency room spokesmen, a majority of power mower injuries occur in late afternoon and evening and are more frequent this time of the year than in late summer and fall.

Lack of Caution

Most power mower injuries are produced by lack of caution on the part of operators. "As with personal injury automobile collisions, it's usually the 'driver' who's at fault," pointed out Roger Justice of the State Health Department's accident prevention service. "Failure to clear the cutting area of rocks, wires, sticks and other debris; reaching down to remove an obstruction or adjust a mower while it's running; and general carelessness

in turning or pushing the mower are the common mistakes that lead to accidents and injury," he stated.

Walter S. prided himself on the appearance of his front lawn with its random planting of pines, shrub-bordered drive and flourishing expanse of cushiony zoysia sod. On the particular Saturday afternoon of Walter's accident, he had come home from the golf course tired, but not too tired to crank the mower and begin cutting the grass. It was an established Saturday afternoon chore, one he had recently made easier and quicker by the purchase of a new, high-speed mower with a grass catcher that eliminated the need to rake the yard after cutting.

Walter was busily swooping along when a stray pine cone became lodged under the mower apron. He stooped down to move the burr, one hand still on the handle. Suddenly the mower slid forward, and Walter gave an agonizing scream. He lost a finger. It could have been worse. It could have been his whole hand.

This accident really happened. Walter is a native Georgian; his real name is not Walter.

"This is a very common type of power mower accident," safety expert Justice commented. "It can be prevented. No one should ever attempt to clean or adjust a mower, or clear the mowing path while the machine is running.

Safety Suggestions

"Other safety suggestions the National Safety Coun-

*"Either we shall master the ways
of political action, or we shall be
mastered by those who do."*

—Raymond Moley

JOIN
GAMPAC

SUBURBIA / Continued

cil and public health officials stress include these," he went on.

- Inspect your lawn before mowing. Be sure there are no stones, sticks, wire or other debris in the area.
- When starting a mower, stand firmly and make sure your feet are in a safe position.
- Cut hills and banks sideways—not up and down—to prevent slipping or sliding.
- Know how to disengage the clutch or stop the engine quickly.
- Disconnect the spark plug wire or electric plug to work on the underside of the mower. Keep hands, feet and clothing away from moving parts. Never at-

tempt removal of any object from the mower until the motor has completely stopped.

- Do not use an electric mower on wet grass.
- Keep bystanders and pets out of the mowing area. Rotary mowers can throw debris and cause serious injury.

"It is estimated that 50 million power mowers are now in use in the U.S.," said the health department spokesman. "It's easy to see why the injury potential is so great," Justice concluded, "especially in suburban areas where lawns tend to be larger and the terrain rougher and rockier than in older, established residential sections. Only through the exercise of caution and good safety practices can we reduce the increasing number of power mower accidents," he said.—Georgia Dept. of Public Health

Rh DISEASE CAN "VANISH" SAYS NEW MEDICAL TEXT

Rh hemolytic disease of the newborn can be virtually eliminated within the next generation. But women are unnecessarily sensitized to the Rh factor when physicians do not prescribe immune globulin because of reliance on negative Kleihauer tests or they fail to recognize that miscarriage and abortion may trigger the immune response.

These points are made in the chapter on "Prevention of Rh Hemolytic Disease" recently published by Grune & Stratton, Inc. in *Progress in Hematology*, Vol. 6. The authors are Drs. William Pollack, Ortho Research Foundation; John G. Gorman and Vincent J. Freda, College of Physicians & Surgeons, Columbia University.

A negative Kleihauer is no guarantee that the mother will not become Rh sensitized, they state. "On the contrary, about 50 per cent of mothers who do become immunized fall into this group. For this reason, the Kleihauer test cannot be recommended for routine use in selecting candidates for prophylaxis. Furthermore, ABO incompatibility between mother and baby, while reducing the incidence of sensitization by about tenfold, does not entirely prevent it. Such individuals should be given the additional protection of Rh immune globulin."

Candidates for Prophylaxis

Noting that about 10 per cent of all pregnancies fail to go to term, the authors say that "although the incidence of sensitization following abortion or mis-

carriage has not been studied as yet, it may be wiser to include such women as candidates for prophylaxis even though the Rh type of the fetus is unknown and cannot be determined."

The scientists estimate that 7½ per cent of all deliveries are in jeopardy of resulting in Rh immunization. "For three and one half million deliveries a year in the United States alone, about 350,000 doses of anti-Rh gamma globulin will be required and a further 88,000 doses will be needed if this protection is to encompass the mothers delivering ABO incompatible Rh positive babies, in whom the risk incidence is about one-tenth that of the ABO compatible group."

"Since the large pool of sensitized Rh negative women will contribute cases of hemolytic disease of the newborn until they pass through the child-bearing period, the effect of Rh prophylaxis on mortality and morbidity will be gradual," the authors say, but "once Rh prophylaxis is universally applied, a decline in the case rate should be between 5 and 10 per cent a year."

Reduction of Problem

Therefore, the scientists conclude, "The present commercial availability of Rh₀ D immune globulin should allow reduction of this public health problem to a vanishingly small incidence within a generation."

Drs. Pollack, Gorman and Freda are codevelopers of a preventive for Rh isoimmunization known as RhoGAM* Rh₀ (D) Immune Globulin (Human). It was made available last year by Ortho Diagnostics.

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As is characteristic of sympathomimetic agents, it may occasionally cause CNS effects such as insomnia, nervousness, dizziness, anxiety, and jitteriness. In contrast, CNS depression has been reported. In a few epileptics an increase in convulsive episodes has been reported.

Sympathomimetic cardiovascular effects reported include ones such as tachycardia, precordial pain, arrhythmia, palpitation, and increased blood pressure. One published report described T-wave changes in the ECG of a healthy young male after ingestion of diethylpropion hydrochloride; this was an isolated experience, which has not been reported by others.

Allergic phenomena reported include such conditions as rash, urticaria, ecchymosis, and erythema. Gastrointestinal effects such as diarrhea, constipation, nausea, vomiting, and abdominal discomfort have been reported.

Specific reports on the hematopoietic system include two each of bone marrow depression, agranulocytosis, and leukopenia.

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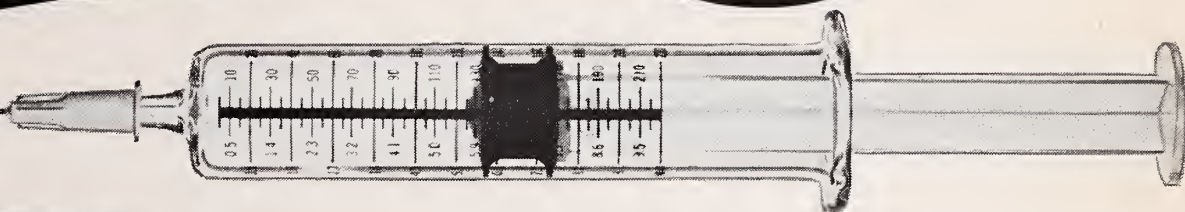
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Cover

Designed by Conrad Guinn of Higgins-McArthur/Longino & Porter.

Multiple factors are implicated in the production of this troublesome condition.

Postoperative Respiratory Insufficiency

ROBERT G. ELLISON, M.D.,* *Augusta*

IT HAS LONG BEEN RECOGNIZED that alterations in pulmonary function occur after major surgery. These abnormalities are more commonly seen after certain types of surgical procedures but may occur in any patient undergoing prolonged general anesthesia and major surgery. Impairment in pulmonary function may be of such severity as to contribute to the morbidity and mortality in the postoperative period.¹⁻⁵

There are a number of specific causes for postoperative respiratory insufficiency. Preexisting pulmonary disease is the most common cause for pulmonary complications after all types of surgery. An increasing number of surgical procedures is being performed upon patients in the older age group. Since the incidence of chronic pulmonary disease is increasing, a larger proportion of surgical candidates have chronic pulmonary disease. Chronic bronchitis, particularly in cigarette smokers, pulmonary fibrosis and emphysema, bronchiectasis, or pulmonary disease secondary to heart disease, such as chronic pulmonary congestion and edema and pulmonary hypertension are all problems that may lead to a high incidence of pulmonary complications.

Even though there have been great refinements in anesthetic techniques, damage to lung and disturbances in ventilation may result in spite of extreme precautions. The influence of the anesthetic agents themselves upon the delicate respiratory apparatus remains to be determined. Even in the most experienced hands, the trauma of endotracheal intubation and suction of secretions during anesthesia and surgery, particularly with the rigid plastic catheters with blunt tips that are used today, invariably lead to

some degree of tracheobronchitis that may influence pulmonary function postoperatively. High concentrations of oxygen delivered with excessive positive pressure ventilation quite likely injure the respiratory apparatus. Furthermore, one cannot ignore the depressing effects upon ventilation of anesthetic agents and the multiple drugs that are necessarily used. The unhumidified anesthetic mixtures and drying agents lead to further damage to the tracheo-bronchial mucosa by drying and inspissation of secretions.

Postoperative Influence

The type of thoracotomy has some bearing upon the ventilatory function postoperatively. Bilateral thoracotomy impairs the mechanics of ventilation more than any other type of exposure, whereas, a median sternotomy has the least influence upon the pulmonary function. Excessive manipulation of lungs by the surgeon may cause congestion, edema or intrapulmonary hemorrhage. Many factors have been implicated as a cause for impaired pulmonary function after extracorporeal circulation. Distention of the left side of the heart is recognized to be deleterious to the left ventricle and also produces over-distention of the pulmonary circulation with serious disturbance in pulmonary function postoperatively. Some of the factors that have been implicated in damage to lung during extracorporeal circulation include denaturation of proteins as a result of trauma at the blood-gas interface in the oxygenator, hemolysis with possible release of histamine and serotonin or peptide with damage to lung and the use of homologous blood. In addition, alteration in blood lipids, sludging or erythrocytes, micro-embolism of such products as air, fat, fibrin, silicone, or red cell aggregates and decrease in pulmonary blood flow with alteration in pulmonary surfactant have been thought to impair pulmonary function. Undoubtedly, all of

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INSUFFICIENCY / Ellison

these factors occur to some extent from time to time and contribute to the development of postoperative respiratory insufficiency.

At this time, it seems that the true role of abnormal surfactant in the production of postoperative respiratory insufficiency remains to be determined. We have evaluated surfactant in lung biopsies in patients with various types of problems including those undergoing extracorporeal circulation. The alveolar bubble stability method proved to be a more sensitive index of surfactant than any other available method.⁶

Stability ratios of lung biopsies were obtained before and after bypass in 125 patients. The stability ratio gives an estimate of surfactant present. The per cent change in stability ratio was plotted against perfusion time and demonstrated that there was no significant alteration in surfactant in the immediate post bypass period.

Factors Altering Function

Postoperatively, a number of factors may alter pulmonary function. Hypoventilation is encouraged by the immobility of the patient resulting from excessive pain or large doses of narcotics to suppress pain, bulky dressings, intravenous fluids and various indwelling catheters and tubes. Also gastric distention, which commonly develops in patients receiving oxygen, limits expansion of the diaphragm and compromises ventilatory function. Excessive tracheo-bronchial secretions are frequently present and if not adequately removed may lead to varying degrees of atelectasis. Oxygen toxicity is being reported in increasing frequency.⁷⁻⁹ In most cases, it has been observed in association with the use of assisted ventilation. Recently, in experimental studies, it was reported that tracheal mucous flow is reduced considerably by inhalation of 100 per cent or 10 per cent oxygen. The high oxygen concentration was thought to inactivate enzymes involved in carbohydrate metabolism important to proper secretion of the mucous glands of the tracheo-bronchial tree.⁹

It is recognized that patients on long term respirator therapy with oxygen develop what is referred to as the "respirator lung syndrome."⁸ The clinical picture is characterized by decreasing pulmonary compliance and progressive hypoxia. At autopsy, such patients are found to have changes similar to those that have been produced experimentally with high oxygen concentrations. In an early exudative phase, there is capillary congestion, alveolar proteinaceous exudate, intralobular hemorrhage, fibrinous exudate and in some cases a hyaline membrane lines the alveolar walls. In a later stage, there is alveolar and interlobular septal edema with fibro-

blastic proliferation and early fibrosis. While the respirator may play some role in production of this picture, it's quite likely that high oxygen concentration is primarily responsible for it.

Diffuse patchy atelectasis is the most common pathological finding in patients with postoperative respiratory insufficiency. This certainly occurs most commonly after pulmonary resections as a result of excessive secretions. In experimental animals and in patients coming to autopsy following a clinical picture of the "pump-lung syndrome," the characteristic pathological findings consist of diffuse, patchy, congestive atelectasis with edema and hemorrhage into alveoli depending upon the severity of the given case.¹⁰ Pulmonary vasculitis, characterized by an extensive polymorphonuclear deposition along the intima of the pulmonary capillaries has also been described. These pathological findings are similar to those observed in hemorrhagic or endotoxic shock.

Reports Describe Injuries

Recently an increasing number of reports have described injury to the larynx and tracheo-bronchial tree as a result of endotracheal intubation or tracheostomy. These findings vary from laryngeal or tracheal ulceration due to endotracheal tube or cuffed tracheostomy tube progressing to stricture or stenosis.¹¹

The pathology described above produces inadequate oxygenation of blood. Hypoventilation or uneven ventilation of alveoli lead to a veno-arterial shunting (perfusion of underventilated alveoli) with an increased percentage of venous admixture to cardiac output and thus a reduction in arterial oxygen tension. In addition, there is a barrier to diffusion of oxygen across the pulmonary membrane, also leading to reduction in arterial oxygen tension.

Decreased pulmonary compliance is another physiological alteration that results from damage to the lung. This leads to an increased work of breathing, which in turn, places an added burden upon the cardio-circulatory system.

Study Findings

In a study of 41 patients, pulmonary compliance was found to be greatly reduced after extracorporeal circulation. Simultaneously there was a reduction in tidal volume, increase in respiratory rate and increase in oxygen uptake. In the same study, venous admixture per cent of cardiac output was greatly increased indicating veno-arterial shunting and reduction in arterial oxygen tension and saturation.¹² Likewise, the carbon monoxide diffusion capacity was found to be greatly reduced.⁴ All of these values slowly returned to normal seven to 10 days after surgery.

Treatment of respiratory insufficiency in the post-

operative period includes prevention, since the manner in which the patient is prepared preoperatively and the management during surgery and postoperatively have considerable influence upon the development of this serious complication. Recognition of preexisting pulmonary disease is essential and accordingly all patients in whom major surgery is planned, regardless of the type, should have some type of preoperative evaluation of their pulmonary functional status. A clinical evaluation will suffice in many patients who are to have major nonthoracic procedures, but if the patient is a cigarette smoker, is over 50 years of age, or if pulmonary abnormalities are suspected from the history or physical examination, screening pulmonary function tests should be performed. All patients for whom major thoracic surgery is planned should have preoperative pulmonary function studies.^{3, 13, 14}

Any preexisting pulmonary disease should be treated vigorously. The most common cause for postoperative respiratory insufficiency is chronic bronchitis secondary to smoking. Accordingly, one should insist that patients stop smoking at least a week or 10 days prior to major surgery. In conjunction with this, aerosol-broncho-dilator therapy, antibiotics and, on rare occasions, steroids are extremely effective in reduction of sputum, elimination of bronchial spasm and improvement in overall respiratory function. In patients for whom cardiac surgery is proposed, maximum cardiac compensation is essential. This leads to reduction in pulmonary congestion and edema and pulmonary hypertension which may seriously influence pulmonary function postoperatively.

Planning Surgery

Surgery should be planned according to the particular problem presented. Sometimes, because of the severity of the preexisting pulmonary disease, a sub-optimal surgical procedure which carries a lower risk than the ideal one, has to be accepted.

During anesthesia and surgery, efforts should be made to minimize trauma to the tracheo-bronchial tree by the anesthesiologist and by the surgeon. Extracorporeal circulation should be conducted in such a manner as to minimize damage to lung. In our experience, high blood flow at normal temperature with moderate hemodilution and avoidance of circulatory overload have resulted in a perfusion which results in minimal postoperative pulmonary complications. Decompression of the left side of the heart to avoid over-distention of pulmonary venous system is essential to prevent deleterious pulmonary congestion.

Postoperatively attention should be directed toward cleansing of the tracheo-bronchial tree. Secretions must be effectively removed. Oxygenation at

normal or just above normal levels should be achieved, and, of course, high humidification is necessary to liquify secretions to aid their removal. Oxygen concentrations in excess of 50 per cent should be avoided to minimize the possibility of oxygen toxicity. In many patients, supported ventilation is helpful where there is serious preexisting pulmonary disease, after extracorporeal circulation or whenever ventilation is found to be inadequate. In recent years there has been a trend toward the use of indwelling nasotracheal tubes rather than tracheostomy in the care of patients requiring supported ventilation. In general, the endotracheal tubes are tolerated well, particularly with the use of small intravenous doses of morphine. Tracheobronchial cleansing is sometimes awkward and inadequate through an endotracheal tube and in our experience, trauma to the laryngo-tracheal apparatus has been as frequent following use of a naso-tracheal tube as after tracheostomy. While many adults have been maintained on supported ventilation with endotracheal tube for many days, it is our current practice to perform tracheostomy if it is felt that endotracheal intubation or tracheostomy is needed for supported ventilation or for tracheo-bronchial cleansing beyond 48-72 hours. Blood gas monitoring during surgery and postoperatively is essential for early detection of lung abnormalities and for determining the effectiveness of oxygen therapy and ventilatory assistance.

By proper preoperative preparation of the patient, careful management of lungs and tracheo-bronchial tree during surgery and diligent postoperative care, postoperative respiratory insufficiency can be minimized or satisfactorily managed in the majority of patients.

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CALENDAR OF MEETINGS

In Georgia

- Sept. 22-26—Course on Control of Rodent-Borne Diseases, National Communicable Disease Center, Atlanta.
- Oct. 6-7—State Conference on Aging, Sheraton-Biltmore, Atlanta.
- Oct. 6-10—Family Practice Symposium, Medical College of Georgia, Augusta.
- Oct. 11—GaMPAC Workshop Conference, Sheraton-Biltmore, Atlanta.
- Nov. 7-8—Georgia Academy of General Practice Annual Session, Marriott Motor Hotel, Atlanta.
- Nov. 10-13—Southern Medical Association Annual Meeting, Atlanta.
- Nov. 16-25—First National Health Show, Atlanta Civic Center.

In the Nation

- Sept. 19-20—Conference on Stroke, Pick-Nicollet Hotel, Minneapolis, Minn.
- Sept. 19-20—Council on Drugs, AMA Headquarters, Chicago, Ill.
- Sept. 19-21—Council on Legislative Activities, Boston, Mass.
- Sept. 19-21—American College of Physicians (Southeastern Regional), Point Clear, Ala.
- Sept. 21-25—International Symposium on Comparative Leukemia Research, Cherry Hill Inn, Cherry Hill, N.J.
- Sept. 21-27—World Congress of Neurological Sciences, New York Hilton, New York, N.Y.
- Sept. 26-Oct. 3—American Academy of General Practice, Philadelphia, Penn.
- Sept. 29—Society for Pediatric Radiology, Washington Hilton Hotel, Washington, D.C.
- Oct. 1-4—The American College of Physicians Course on Vascular Disease, Mayo Clinic and Mayo Graduate School of Medicine, Rochester, Minn.

- Oct. 6-10—American College of Surgeons, Fairmont Hotel, San Francisco, Calif.
- Oct. 8-11—The American College of Physicians Course on Medical Oncology Today, Center for Continuation Education, University of Minnesota Campus, Minneapolis, Minn.
- Oct. 8-11—National Hemophilia Foundation, Drake Hotel, Chicago, Ill.
- Oct. 8-11—National Conference on Physicians and Schools, Pick-Congress Hotel, Chicago, Ill.
- Oct. 11-12—American Association of Ophthalmology, Palmer House, Chicago, Ill.
- Oct. 12-17—American Academy of Ophthalmology and Otolaryngology, Palmer House, Chicago, Ill.
- Oct. 12-16—American Society of Plastic and Reconstructive Surgeons, Chase-Park Plaza, St. Louis, Mo.
- Oct. 13-14—Tennessee Valley Medical Assembly, Memorial Auditorium, Chattanooga, Tenn.
- Oct. 18-23—American Academy of Pediatrics, Palmer House, Chicago, Ill.
- Oct. 23-25—Annual Scientific Meeting of the Southeastern Chapter of the Society of Nuclear Medicine, Sheraton Nashville Hotel, Nashville, Tenn.
- Oct. 25-29—American Society of Anesthesiologists, San Francisco Hilton, San Francisco, Calif.
- Oct. 29-Nov. 2—American College of Chest Physicians, Palmer House, Chicago, Ill.
- Oct. 31-Nov. 3—Association of American Medical Colleges, Netherlands Hotel, Cincinnati, Ohio.
- Nov. 3-7—Nuclear Medicine: Diagnosis and Treatment of Disease with Radionuclides Given Internally, the University of Michigan Medical Center, Ann Arbor, Michigan.
- Nov. 17-21—Correlative Neuradiology, New York University Post-Graduate Medical School, New York, N.Y.

With the thrice-daily dosage schedule, results were excellent in 90 per cent of the patients.

Sulfamethoxazole* Suspension in Acute Urinary Tract Infection in Children

PRESTON D. ELLINGTON, M.D. and ALFRED J. GREEN, M.D., Augusta

Forty-nine children, aged from 3½ months to 12 years, with acute urinary tract infection, were treated with sulfamethoxazole suspension. Dosage ranged from 0.25 to 2.0 gm initially and from 0.25 to 1 gm twice daily thereafter, for 5 to 14 days. Results were excellent (complete remission of clinical symptoms usually within 24 hours, and no growth on the first post-therapy culture) in 90 per cent, good in 2 per cent and fair or poor in 8 per cent. Bacteriologic conversion from positive pretreatment to negative post-treatment cultures occurred in 40 of 44 patients showing *E. coli* organisms, in five of six with *Proteus* and all three with *S. aureus*. The sulfamethoxazole suspension was well accepted by the children and the twice-daily dosage schedule

greatly simplified treatment. One child vomited after the first dose. There were no other side effects.

Sulfamethoxazole (5-methyl-3-sulfanilamidoxazole) tablets have been used successfully in urinary tract infections in adults^{2, 3, 5} and children.¹ In one study of uncomplicated urinary infections in adult females the bacteriologic conversion rate was reported to be 100 per cent.⁵ The suspension has been given to children with upper respiratory infections. We evaluated the usefulness of the suspension in acute uncomplicated urinary tract infection in children in a busy pediatric practice.

Methods and Materials

The study included 50 children, 45 females and 5 males, ranging in age from 3½ months to 12

* Gantanol®, product of Roche Laboratories, Division of Hoffmann-La Roche Inc., Nutley, New Jersey.

TABLE I
BACTERIOLOGIC AND CLINICAL RESULTS

Diagnosis	No. of Patients	Pre-Treatment Culture	Post-Treatment Culture	Clinical Response
Cystitis, acute	12	<i>E. coli</i> 11	<i>E. coli</i> 1	Exc. 12
Hemorrhagic cystitis acute	1	<i>Staph. sp.</i> 1	neg. 1	Good 1
Cystitis, chronic	1	<i>Staph. sp.</i> 1	neg. 1	Fair 1
Pyelonephritis, acute	9	<i>Proteus sp.</i> 1	<i>Proteus sp.</i> 1	Exc. 2 Fair 1
		<i>E. coli</i> 5	<i>E. coli</i> 3	Poor 2
		<i>Proteus sp.</i> 3	neg. 3	Exc. 3
		<i>S. aureus</i> 1	neg. 1	Exc. 1
Pyelonephritis, chronic with acute exacerbation	2	<i>E. coli</i> 2	neg. 2	Exc. 2
Pyuria, acute	22	<i>E. coli</i> 20	neg. 20	Exc. 20
		<i>Proteus sp.</i> 2	neg. 2	Exc. 2
Pyuria + acute cystitis	1	<i>E. coli</i> 1	neg. 1	Exc. 1
Urinary tract infection, acute	1	<i>E. coli</i> 1	neg. 1	Exc. 1
				Exc. 44
				Good 1
				Fair 2
				Poor 2
Total	49	49	5	49

years. As one child failed to return for a follow-up visit, results are available for 49 patients. Acute primary urinary infection was present in 46 patients, and acute exacerbation of chronic conditions in three patients (Table I).

Urine specimens were obtained before and after therapy (except in six cases where specimens were taken before and during treatment) usually by catheterization, but in some cases by collecting cleanly voided midstream specimens. Cultures were done immediately after collection of specimens. Before treatment, *E. coli* was cultured in specimens from 40 patients, *Proteus* in six and *S. aureus* in three.

The dosage of the drug was adjusted according to the weight and age of the patients. It ranged from 0.25 to 2 gm initially, and from 0.5 to 1.0 gm b.i.d. thereafter. Treatment was continued for five to 14 days.

Results and Conclusions

Bacteriologic conversion from positive to negative occurred in 44 of the 49 patients. (Table) *E. coli* was eradicated in 36 of the 40 patients. Only one of six *Proteus* infections failed to clear completely, and post-treatment urine became sterile in all three patients showing staphylococci prior to treatment.

Results were judged excellent (complete remission of symptoms within 24 hours or later in some

cases and no growth on the first post-treatment culture) in 44 patients (90 per cent), good (remission of symptoms within 36 hours and no growth on a second post-treatment culture) in one (2 per cent), and fair or poor (remission of symptoms within 72 hours or limited remission and continued growth on the first post-treatment urine) in two each (8 per cent). Clinical and bacteriologic results generally correlated except in one case where bacteriuria persisted despite subsidence of symptoms. The only side effect was vomiting after the first dose by one child who tolerated subsequent medication. Children found the suspension palatable and mothers found the twice-daily dosage schedule convenient.

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CONCLAVE OF COMMITTEES

The fabulous Atlanta Marriott, world's largest motor hotel, was once again the scene for MAG's Annual Conclave of Committees. This second annual conclave, held July 26-27, saw 31 committees meet, bringing together 100 members and giving MAG's committee programs their best beginning yet.

The meetings opened with the first session of the Annual Conference of MAG Committee Chairmen. MAG President John Kirk Train, M.D., who presided over the entire conclave, opened the Chairmen's Conference with a brief review of the 1968 conclave and its many accomplishments. Twenty-five committee chairmen heard Eugene Griffin, M.D., chairman of MAG's Committee on Maternal and Infant Welfare, remind them that the success of any committee would be proportionate to the interest, enthusiasm and activity of its chairman. Mr. J. Tom Sawyer, assistant director, AMA Division of Public Service, reviewed the status of the

Committee Conclave in other states and praised MAG for the format and accomplishments of the conclave idea.

The annual party on Saturday evening which served as a gathering place before dinner drew 100 participants with wives and husbands. An additional feature of this Second Annual Conclave was the Woman's Auxiliary to MAG Summer Board Meeting and Workshop. Active sessions on Friday and Saturday launched the Auxiliary program for 1969-70.

The conclusion of the Conclave brought reports from the 31 committees on their current activities and future plans. The Executive Committee of Council, which met immediately following the closing of the Conclave, took note of the success of the 1969 Conclave and expressed the hope that this will continue to be an annual highlight of MAG's program.

Wilson's Disease

THOMPSON A. GAILEY, JR.,* and GEORGE R. MUSHET, M.D.,† Augusta

MR. GAILEY: THE PATIENT TODAY is a 22-year-old white female from Savannah, Georgia, who was in excellent health until April, 1967, when she developed cystitis. In May she noted mild pedal edema and was treated successfully with a diuretic. Her urine, however, continued to contain albumin and white cells and she was therefore hospitalized in Savannah in July, 1967. An intravenous pyelogram was normal but urine cultures revealed *E. coli* sensitive to Furadantin. Her physicians thought that she had pyelonephritis and that her fluid retention was related to recurrent kidney infection. She was discharged on Furadantin and Lasix. She did well for several days but then rapidly became anemic and jaundiced. Hepatitis was considered and she was referred to Dr. James Metts, Jr., of Savannah, in late July, 1967. Although serum bilirubin was quite elevated, transaminases never rose significantly. She did, however, have marked reticulocytosis and was thought to have acute hemolytic anemia secondary to either Furadantin or an undiagnosed disease. This hemolytic crisis subsided spontaneously when medications were discontinued. Upper G.I. series, IVP, and barium enema were normal. Her gallbladder failed to visualize after either double doses of oral dye or intravenous cholangiography. A Rose Bengal study was normal, but BSP retention was distinctly abnormal. She continued to have mild increases in bilirubin and reticulocytes as well as prolongation of prothrombin time to 25 seconds despite the administration of Vitamin K-1 oxide.

In early September, 1967, she developed generalized edema and was treated with Aldactone, which caused a 20 pound weight loss in several days. She also experienced intermittent cramping pains in shoulders, arms, legs, and fingers. In late September, 1967, she again developed massive edema, but this subsided in several days with bed rest and aldactone.

A consultant raised the question of hereditary lymphangiectasia involving the intestine or lupoid hepatitis. She was then transferred to Memorial Hospital, Savannah, for lymphangiography. This study, as well as rectal and muscle biopsies, were normal. She had increasing ascites and generalized edema and developed coma, confusion, and clonic movements. Wilson's Disease was suggested by Dr. Metts but both serum copper and ceruloplasmin levels were reported as borderline normal in early November, 1967, and no Kayser-Fleischer rings were seen. Several consultants felt that the edema was due to hypoproteinemia, although serum albumin was only moderately decreased. Several abdominal paracenteses were performed and the ascitic fluid was re-infused intravenously. She was also given one unit of salt-poor albumin daily for 10 days with general improvement. She looked well at the time of discharge in late November, 1967, but elevated prothrombin time and generalized coagulation defects remained.

In late December, 1967, she again developed edema and was again treated with daily infusions of albumin with some improvement. The night before admission to Talmadge Hospital she became very anxious and was sedated with Demerol and Vistaril.

Family History of Importance

The family history was contributory in that the patient's 26-year-old brother, a non-drinker, was admitted to a local hospital with bleeding esophageal varices and a prolonged prothrombin time was found. The patient's parents were also distantly related.

On admission to Talmadge Hospital in late January, 1968, the patient's vital signs were normal and stable. She was generally unresponsive and eyes moved in a random, uncoordinated manner. The sclerae were slightly icteric and there was minimal pre-tibial and ankle edema. There was also a peculiar foul-sweet odor to her breath and she intermittently assumed a rigid flexed position of her upper extremities.

* Junior Medical Student.
† Assistant Professor of Neurology.
These conferences are taped weekly and are selected and edited by Dr. A. Calhoun Witham, Professor of Medicine, Medical College of Georgia. The participants are principally faculty and house staff of the Department of Medicine, or Junior Medical Students assigned to the patients. Members of other departments are so identified.

Prothrombin time was 51 seconds and factors IX, X, and fibrinogen were decreased. Vitamin K gave no response but the administration of fresh blood decreased the prothrombin time to 36 seconds. Since the patient was thought to be in hepatic failure, a low protein high carbohydrate diet, and oral and rectal neomycin was begun. The serum ammonia on the third hospital day was greater than 225 micrograms per cent (normal less than 75). Modumate (arginine glutamate, an ammonia binding agent) was begun and the patient became more alert after several days.

Wilson's Disease Indicated

On the ninth hospital day a urinary copper of 273 micrograms per 24 hrs. (upper normal 70) was reported and elevated excretion was repeatedly confirmed. Depressed serum coppers concentrations of 41 and 40 micrograms per cent (less than 80 seen in Wilson's Disease) clearly pointed toward a diagnosis of Wilson's Disease, but no Kayser-Fleisher rings were seen by the ophthalmologists. The diagnosis was firmly established when a serum ceruloplasmin level of 118 units (normal 280-570) was reported and when re-examination of her cornea with a slit lamp revealed Kayser-Fleisher rings.

The patient's prothrombin time finally stabilized in the range of 30 seconds. Another interesting feature was that her alkaline phosphatase steadily rose to a value of 40.5 King-Armstrong units and then began spontaneously to subside so that it was 25 units at the time of her discharge. Her total serum proteins dropped as low as 4.5 grams and she was treated with albumin infusions. Surprisingly there was little edema accompanying this drop. A platelet count of 50,000, which responded little to steroids, was also a persistent problem. About one week before discharge she developed a definite tremor of her hands and her signature was almost illegible.

She was begun on penicillamine, a copper chelating agent, one week prior to discharge. She appeared well and had no physical findings except for tremor and a palpable spleen first noticed just before discharge. She is being followed by Dr. Metts for any complications or reactions to her therapy. The diagnosis of Wilson's Disease has subsequently been established in her brother.

Discussion

Hepatolenticular Degeneration, Wilson's Disease, is predominantly a disease of childhood and early adult life in which cirrhosis of the liver is associated with cerebral lesions, predominantly in the basal ganglia. The onset of symptoms is usually between

the ages of 10 and 25 years and only unusually after the age of 40. Its familial nature and transmission in a recessive manner is generally accepted.¹

Symptoms of hepatic and cerebral disease vary greatly from case to case, but there is some evidence that the disease in certain families conforms to a rather distinctive clinical and biochemical pattern. In some instances the whole course may be that of hepatic cirrhosis with recurrent jaundice, ascites, hematemesis and other hemorrhagic manifestations, and terminal hepatic coma. The majority of cases, however, seem to present with neurologic symptoms but upon close questioning they also usually have symptoms suggesting hepatic disease.¹ The symptoms of cirrhosis, if present, are by no means distinctive and no characteristic disturbance of liver function has ever been found. The Kayser-Fleisher rings would seem to be a constant and pathognomonic finding in symptomatic individuals.²

Metabolic Disorder

The body of evidence is that there is a highly specific metabolic disorder that underlies both the hepatic and the cerebral lesions. There is an increased copper concentration in liver, brain, and the pigment of the corneal ring. The liver of the usual cirrhotic patient also contains increased amounts of copper, but not to the degree of that found in Wilson's Disease.

Copper is a normal trace element essential for life but only 2 mgm. a day are necessary to maintain a positive balance.³ The greatest part of the normal serum copper is found in the specific alpha-2 globulin ceruloplasmin. A small percentage of serum copper is also loosely bound to albumin and an even smaller unbound part is capable of traversing the glomerulus, thus accounting for the minute amounts present in normal urine (usually less than 100 micrograms per 24 hours).⁴

Copper newly absorbed from the intestine is first attached to plasma albumin but is rapidly transferred to ceruloplasmin in the normal individual.⁴ Normally there seems to be some mechanism that prevents over-absorption of copper from the gut, but little is known of such factors.¹ The metal seems to be largely protein-bound in tissues and specific copper-protein complexes exist normally in liver and brain, especially in the basal ganglia.⁵

Copper Metabolism Variance

Copper metabolism in this disease, therefore, varies from the normal in many respects. The urinary excretion of copper is greatly increased and this increase is highly specific for the disease. The copper content of the feces is markedly decreased so that the patient remains in positive copper balance

despite the increased loss in the urine.⁶ This would lend support to the concept that increased intestinal absorption of copper is an integral part of this disease. A decreased serum copper is usually found and this is said to be due to a decrease in ceruloplasmin which normally binds the majority of serum copper. It is essential that one not overstate the case of the role of ceruloplasmin in this disease for it is certainly true that there is no correlation between its severity and the ceruloplasmin level. Moreover, there are several proven cases of Wilson's Disease in which the ceruloplasmin levels have been normal.⁷ It is therefore plausible to postulate that there may be a qualitative as well as a quantitative defect in ceruloplasmin synthesis.

In addition, an amino aciduria of renal origin has been found in many cases.^{1, 8} Renal glycosuria⁹ is an occasional finding and there is also a failure of tubular reabsorption of phosphate¹⁰ and urate.² In addition to tubular defects, there is also a reduction in the glomerular filtration rate² but no convincing pathologic lesion has been found in the kidney.

The most accepted theory for the pathogenesis of this disease is that failure to synthesize normal ceruloplasmin leads in some way both to life-long over-absorption of copper and to its diversion from normal metabolic pathways.^{1, 2} The renal, hepatic, and cerebral defects would thus be due to the accumulation of toxic amounts of copper. Another theory, proposed by Uzman,¹¹ is that there is a congenital defect in protein metabolism so that abnormal proteins and peptides with a greatly increased avidity for copper are present in the tissues. This, therefore, leads to an abnormal accumulation of toxic amounts of copper. Needless to say, both of these theories have their own specific faults and neither adequately explains all of the biochemical features.

Purpose of Treatment

Since accumulation of toxic amounts of copper is a basic finding in Wilson's Disease, treatment is designed both to restrict the dietary intake of copper and to facilitate the removal of copper from the body by chelation. Unfortunately, it is impossible to reduce the intake to desired levels. This necessitates the addition of agents such as potassium sulfide to meals to reduce copper absorption. Penicillamine, a copper chelating agent, is being used to promote a large increase in copper excretion from the body.² This compound, which can be taken by the mouth, is not as toxic as the previously used BAL but fever, drug rashes, nephrosis, and leukopenia are sometimes seen.¹²

The natural course of this disease is usually rapidly downhill if untreated but spontaneous remissions, which make therapy difficult to evaluate, are seen.

The neurologic manifestations generally respond more favorably to therapy than do the hepatic. Those patients, however, who have severe brain lesions could not be expected to respond well.²

In most instances, a diagnosis of Wilson's Disease can be made before the onset of symptoms and prophylactic therapy with penicillamine begun. The recognition of a serum ceruloplasmin level of less than 20 mgm. per cent associated with a copper content of greater than 250 micrograms per gram of dry weight of liver tissue in an asymptomatic individual is most probably an indication to begin therapy.¹³

The key to successful therapy, as with any other disease, is early recognition and treatment. The laboratory means are at hand for diagnosis prior to the development of any clinical manifestations. It seems unusual, at least to this student, that such a rare entity can be treated prophylactically while our common illnesses can only be palliated.

Copper Toxicity a Factor

DR. MUSHET: As Mr. Gailey mentioned, the bulk of the current evidence favors the concept that chronic copper toxicity is a major etiologic factor in the production of the hepatic and cerebral lesions in Wilson's Disease. The inborn metabolic error generally operates as an autosomal recessive trait, but exhibits enough variance in its clinical presentation to suggest the presence of modifying and mutant genes.¹⁵ Although the consequences of the genetic defect are well described, the primary pathologic event has yet to be proved. There are two major concepts in vogue.¹⁴ One suggests that because of a decrease in tissue carboxypeptidase, polypeptides are formed which have a high affinity for copper which becomes tissue bound to the abnormal residue. In this theory deficiency of ceruloplasmin is a parphenomenon. The circulating copper peptides are, in this hypothesis, considered responsible for the blockage of tubular reabsorption of amino acids and the resultant amino-aciduria commonly seen in Wilsonian patients. There has been little evidence for, and much against, the concept of abnormal copper binding protein in cerebral and hepatic tissue.

A more accepted hypothesis is that the copper binding protein ceruloplasmin, shown experimentally to be a tissue copper donor is inadequately synthesized in patients with Wilson's Disease. Therefore copper becomes free to be bound to what has been demonstrated to be normal brain, liver, and renal tissue proteins.¹⁸ When these become saturated, cellular dysfunction rapidly proceeds and the clinical disease reaches its zenith.

Copper balance in Wilson's Disease is clearly positive both by radioactive copper (CU 64) kinetic

studies and by the demonstration of increasing copper deposition in tissue over a period of years.¹⁸ The additional possibility of an increased intestinal absorption of the metal has been suggested. In the homozygote it has been shown that copper 64 is initially bound to albumin, then shows a rapid diffusion into the various affected organs during the first hour and that the half time of disappearance is not significantly different from the normal individual. However, the patient with Wilson's Disease will continue to show a decrement in plasma radioactive copper while the normal will achieve a steady state within 24 hours as the copper becomes related to ceruloplasmin. The heterozygote for the Wilsonian gene with normal ceruloplasmin levels (greater than 20 mgm. per 100 cc. serum) may show a copper kinetic sequence similar to the Wilsonian patient which has been thought to represent an additional disturbance in the binding of copper to ceruloplasmin as a secondary pathogenetic feature. This qualitative ceruloplasmin defect has been suggested but as yet not proved.

Important Enigma

An important, recently publicized, enigma in Wilson's Disease is detection of the presymptomatic individual.¹⁷ This, of course, is imperative because the disastrous consequences of the disease may be prevented by adequate therapy.¹⁶ Asymptomatic homozygotes for Wilson's Disease may show increased urinary copper excretion and depressed ceruloplasmin levels. This in itself, however, does not distinguish them from the heterozygote carrier who will never develop the clinical disease. It is now considered by many investigators that a hepatic liver concentration over 25 milligrams per 100 grams dry weight is sufficient to establish the diagnosis of Wilson's Disease in many of these individuals.¹⁷ An exception to this is in the physiologic hypoceruloplasminia and elevated hepatic copper of healthy newborn infants which persists for the first six months of life. Hepatic copper determination is, of course, of major importance in the evaluation of juvenile cirrhotics who have not yet demonstrated the neurologic symptomatology of Wilson's Disease.

Wilson's Disease was untreatable until the development of BAL during the second World War. This chelating agent has now been largely replaced by penicillamine which is capable of producing a negative copper balance, can be taken orally, and is considerably less toxic than BAL. Neurologic manifestations diminish, liver functions improve, and Kayser-Fleisher rings may entirely resolve with proper therapy. A low copper diet including the

avoidance of drinking water high in copper has been recommended. The abnormal movements of the Wilsonian patient can frequently be controlled by the phenothiazine compounds or Diazepam and coexistent hepatic failure symptomatically managed.

Medical College of Georgia

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REPORT OF AMA VOTE

Mason I. Lowance, M.D., reports that the Allergy Section of the American Medical Association voted 160-49 to support the application for an Independent Board of Allergy, at the AMA meeting in New York on July 14. This resolution was then acted on favorably by the Reference Committee and House of Delegates.

Many specific and useful suggestions are advanced for improving attendance.

Building Attendance at County Medical Meetings

JOE S. ROBINSON,* M.D., *Macon*

THIS IS NOT A SCIENTIFIC PAPER and it is a very difficult subject to write or talk about. There is no literature, of course, on this subject and there have been no ideas promulgated or set forth or any kind of criteria established for promoting attendance at county medical society meetings. One must also realize that doctors are a peculiar breed of people and they don't like to be told, or dictated to, or they would never have chosen such a field of work. There are a few points, though, that we of the Bibb County Medical Society feel should be emphasized. We will attempt to bring some of these points to your attention.

Perhaps the first thing to be considered would be organization and leadership. Without sufficient leadership, no society can function as a well-organized unit, and consequently enthusiasm will not be maintained and attendance at meetings will therefore not remain at a maximum. All of the 176 practicing physicians in our county maintain an active membership in our Society. It is felt that committee appointments can be made to help maintain some of this enthusiasm. These appointments should be made to fit the personality of each individual physician so that he may have some peculiar interest in the assignment. The more important committee assignments need to be assigned to the more aggressive members of the Society so that we may be sure that the job is done. We continue to encourage attendance at meetings beyond the age of 70 although these members are excused from paying dues. We also extend a standing invitation to all the interns and residents in our hospital and encourage their attendance at our meetings without any cost to them.

The next most important point to consider, perhaps, is that of the time of day and the day of the month to hold these meetings which might be most receptive to the most doctors. We have found that a dinner meeting with at least a half-hour of social get-together with cocktails has proven of much help. We have found that a social hour from 6:30 to 7:00 has been convenient for most of our physicians. Although we do not limit the speaker's time on the scientific program, we try to finish the evening's activities by 9:00 or 9:30.

Meeting Place Important

Also of much importance is the place where this dinner is to be held since it should be a convenient place to most of the doctors in the area. This meeting place should be other than that of a downtown area. Adequate parking space is, of course, vital and essential. Doctors fight the traffic battle most of the day and they like to get out to a place where there is less crowding.

Of much importance is the kind and quality of food that one may obtain at this meeting place. We have found that most of our doctors like to eat steak and all the trimmings that go along with it, and perhaps that's the reason that seven out of 10 of us develop coronary atherosclerosis and die before our time—we just simply eat too much fat. We must stress again that this is an hour or two of socialization and the hour with cocktails before dinner is served is of great appeal to most of our doctors. We usually have the hors d'oeuvres and other essentials along with a self-service bar which is set up and looked after by our own Secretary.

We actually have 10 meetings per year. We do not have a meeting in May since this is the time

* President, Bibb County Medical Society.

MEETINGS / Robinson

of the State Medical Association meeting. We also have found that attendance in July is always poor since so many doctors are away on vacation and have felt it unwise to attempt to hold a meeting during this month. During the month of August it has been tradition in our Society to have an annual picnic. This picnic has always been most successful and enjoyable when held at someone's retreat near a lake side. For a number of years, the Bibb County Medical Society attempted to hold the December meeting at the Bibb County Public Health Building so that expenses might be eliminated and since, too, this was a meeting for election of officers and usually there was considerable time consumed but this had to be abandoned because of such poor attendance. We found that there frequently were not enough members present to have a quorum and, therefore, the election could not be held. We eventually gave up and went back to the regular meeting with a social hour with cocktails and followed by the usual meal. We do not have a scientific program at this meeting, however.

Atmosphere a Factor

Another factor to be considered is the atmosphere of the place where the meeting is held. Doctors like to take this as a period of rest, relaxation and recreation and also do not like to be in an area where there are other people. About three years ago it became necessary to look for a new meeting place because of changes in the management of the place where we had been meeting for quite a long time. The price of food here had gone up and other things had changed which we did not like. We moved to a new place, somewhat more exclusive and more private, and with very good management only a block down the street. We have a filet mignon with the other trimmings. This was the meal to be served, in agreement with the management, when we changed places. The doctors, therefore, know in advance just what they will be served. Since moving,

we have had over 20 per cent increase in attendance. We feel that perhaps the changing to the new place has been largely responsible for this.

The other very great factor, though, and perhaps the most important one, is that although doctors like to have an hour or two of relaxation and socializing, they do not like to waste their time and like to be fed something besides food. We feel that a very good scientific program is always well received and very well appreciated. We have tried to stay away from the fields of speciality since they appeal only to perhaps two or three or four doctors in the entire audience but to the contrary we have attempted to find speakers in any field of Internal Medicine or General Surgery. These talks have been well received and we have been fortunate in finding very excellent speakers so that our members look forward to attending our meetings and feel that they have acquired something beneficial in the way of keeping up with current medicine or surgery.

We have found it helpful as well as convenient to pay a qualified technician to see that speaking amplifiers, slide projectors, movie projectors and other equipment is properly set up and in good working order.

Financing of Programs

There are ways and means of financing these programs and I would like to suggest that you contact some of your drug representatives. I am sure they can be of help. One of our programs is supported entirely by a lay citizen of our city who had a son to die with leukemia several years ago. He became acutely interested in medicine and we have a standing one-man committee who is in charge of obtaining a suitable speaker for this special occasion once a year. I am sure that this might be duplicated in most any other community.

In conclusion, then, we would like to emphasize that good leadership, good fellowship, good food, and a good scientific program will go a long way toward improving attendance at your county medical meeting.

655 First Street

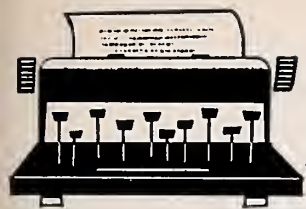
GaMPAC WORKSHOP

Sheraton-Biltmore Hotel

Atlanta

OCTOBER 11, 1969

All Physicians & Wives Invited



A Promise for the Mentally Ill

THE 1969 AMENDMENT OF THE "GEORGIA HEALTH CODE" presages considerable improvement in our care of mentally ill patients who require hospitalization. It has two main sections: the so-called "Bill of Rights" which essentially insures that no one will lose rights granted to them by our government solely because they are mental patients; and a modernization of procedures for admitting people to such institutions. Like all such legal documents, it is detailed and verbose. Since no law is of any value unless it is both understood and properly used, it is the purpose of this presentation to highlight the essential features of the law.

RIGHTS OF PATIENTS: "Protection of patient's rights—The individual dignity of the patient shall be respected at all times and upon all occasions, including any occasion wherein the patient is taken into custody, detained, or transported. Except where required under conditions of extreme urgency, those procedures, facilities, vehicles, and restraining devices normally utilized for criminals or those accused of crime shall not be used in connection with the mentally ill. Mentally ill patients or those suspected of being mentally ill shall, to the maximum extent reasonably possible, be treated at all times as medical patients and their handling and treatment shall be under the *supervision of a physician*. No person who is receiving or has received services for a mental disorder shall be deprived of any civil, political, personal, or property rights without due process of law."

The act further requires that patients receive care and treatment suited to their needs, that if desired they may be allowed to see a private physician, that no mechanical restraints be used unless absolutely necessary, communication and visiting and use of the mails shall be unhindered, patients may vote if otherwise eligible and be employed outside of institutions. Data given by the patient are considered confidential and not a matter of public record. If needed, the patient is given legal counsel. It is emphasized that facilities used for criminals, such as jails, police cars, etc. are not to be used except in dire emergencies. As a protection to professionals and others, anyone who acts in good faith to comply with these provisions with respect to the admission or discharge of a patient is immune from liability.

VOLUNTARY ADMISSIONS: Any person 18 years or older who desires may voluntarily apply for admission to state institutions, and if found in need of treatment may be given such care and treatment. Should the voluntary patient desire release, a written request is submitted to the hospital and within five days he must either be released, or if the superintendent feels that discharge would be unsafe to the patient or others, proceedings for involuntary admission must be initiated.

EMERGENCY ADMISSION: "Any physician may execute a certificate stating that he has examined a person within the preceding 48 hours and found that the person appears to be mentally ill and is likely to injure himself or others, and the observations upon which that conclusion is based. The physician's certificate authorizes any peace officer to take the person into custody and to deliver him forthwith to the nearest available Emergency Receiving Facility, where he shall be received for examination. The peace officer shall execute a written report de-

tailoring the circumstances under which the person was taken into custody, and this report and the physician's certificate shall be made a part of the patient's clinical record."

"(a) If a person is committing a penal offense, as defined in Section 88-501(n) and if there is probable cause for believing the person to be mentally ill and a danger to himself or others, or

"(b) a person is overtly threatening to commit suicide, a peace officer may take the person to a physician, within the county or an adjoining county, for emergency examination by the physician, as provided in Section 88-504.2."

(The law allows counties to opt to not be included under these provisions; it is hoped that most, if not all, Georgia counties will retain this humane, medical procedure.) This patient must be examined as soon as possible, certainly within 24 hours, and given emergency treatment as indicated by good medical practice. The patient must be released within 24 hours of admission unless the examining physician concludes that there is reason to believe the patient may require hospitalization in a treatment facility and executes a certificate to that effect.

ADMISSION FOR EVALUATION: "(a) Any person may file an application executed under oath, with the County Health Department for a court-ordered evaluation of a patient located within the county who is alleged to be mentally ill and (1) a danger to himself or others or (2) incapable of caring for his physical health and safety." When such application is filed, the County Health Department determines whether these criteria are met. If so, a petition is filed with the Court of Ordinary. If there is not sufficient time for inquiry by the Health Department, the petition may be filed directly with the Court, if supported by a physician's certificate showing the need for evaluation. The court may then order the individual to an evaluating facility for a period not to exceed five days.

INVOLUNTARY HOSPITALIZATION: NON-OBJECTING HOSPITALIZATION: When the patient has been examined in such an evaluating center and two physicians deem hospitalization necessary, the patient may be hospitalized for purposes of treatment for up to six months unless he objects, in which case procedures for legal hearings are outlined. There are elaborate legal safeguards for patients, including requirements for review of public records each six months, appointment of counsel if the patient is unable to afford same, designation of individuals who act as representatives of the patient, etc.

JUDICIAL HOSPITALIZATION: If the patient objects to hospitalization, procedure similar to that currently in existence, i.e. appearing before Court of Ordinary with an examining commission consisting of two physicians and one attorney, is carried out. This would also be the procedure when a county elects not to use the various other admission procedures.

As can be seen, this law should make it possible for physicians to treat patients promptly, making hospital admission a simple, medical procedure and removing many of the past stigmata of treatment of mental illness. In this way some of our promises to the mentally ill will be fulfilled.

Sheldon B. Cohen, M.D.

A serious illness or a death advertises the doctor exactly as a hanging advertises the barrister who defended the person hanged. Suppose, for example, a royal personage gets something wrong with his throat, or has a pain in his inside. If a doctor effects some trumpery cure . . . nobody takes the least notice of him. But if he operates on the throat and kills the patient, or extirpates an internal organ and keeps the whole nation palpitating for days whilst the patient hovers in pain and fever between life and death, his fortune is made.

—George Bernard Shaw



THE SIGHTS AND SOUNDS OF JULY 15 AND JULY 16

AND WE WILL HAVE A MAN ON THE MOON in this decade." These and other words from a tape recording of a speech made by the late John F. Kennedy opening a 30-minute tape, slide and movie presentation describing the achievements and hopes of our space program, were our introduction to our guided tour of Cape Kennedy and the John F. Kennedy Space Center on July 15, the day before the launching of Apollo 11 with its occupants destined to be the first humans to set foot on the moon. Because we were "badged," we were given a more extended tour than the usual visitor and this presentation was one of the extra benefits that we "VIP's" enjoyed. My invitation came to me as President of MAG, and I was happy to be among the many so honored. The tour took us to all the sights of interest in the space center, the complexes where the various missiles have been and still are being launched, inside one of the control rooms with its multiple screens and dials monitored during a launch, to within half-a-mile of Apollo 11 sitting on its pad, astronauts aboard, countdown, needless to say, in progress; to the V.A.B., the Vertical Assembly Building, some 525 feet high, where the Apollos are assembled, vertically; where Apollo 12 now stands assembled and Apollo 13 nearly so. But this tour was only a prelude to the day of the launch.

Much has been written on this subject and much more will be, but to sum up, one has to be there to appreciate a launch. The absolute assurance of those connected with the space program that everything will go as scheduled mirrors the work and effort that have gone before to make certain that this launch will be perfect.

The crowd gathers, several thousand strong, in the area reserved for those with badges. There are stands for all and a large grassy roped-off area in the shadow of the Vertical Assembly Building, some three-and-a-half miles from "The Pad," the closest anyone is allowed. A voice over the speaker gives the countdown, tells of arrival of "VVIP's," directs the standees as to where to stand; people of all descriptions with cameras of all sizes mill around: there is one girl all of four-and-a-half feet tall, with a camera at least three feet long.

As the count goes down, the air of excitement goes up and at the end of the count the crowd is quiet, only the voice of the counter is heard. At zero the flame of ignition is seen and a spontaneous cheer goes up from the thousands of watchers, then slowly the giant separates itself from Earth; 15 seconds later the ear-shattering noise of the blast-off, of which you have been warned but for the magnitude of which you are still not prepared shakes you and the earth; more cheers as the second and third stages ignite and Apollo is off for the Moon; and the watchers depart, back to their earth-bound lives.

Back to an earthly traffic jam stretching bumper-to-bumper the 60 miles back to Daytona Beach; back to U.S. Highway No. 1, half of which is blocked by the Reverend Mr. Abernathy and his "Freedom Marchers," and his mules; back to the radio that informs us as we are about a third of the way back to Daytona that Armstrong, Aldrin and Collins have just passed the Australian tracking station.

I had read that to be a true believer in the space program one has to have been present at a launch. I am a believer.



John Kirk Train, M.D.
President, Medical Association of Georgia

RANDOLPH-STEWART-TERRELL COUNTY MEDICAL SOCIETY RESOLUTION

WHEREAS, the House of Delegates of the Medical Association of Georgia in May, 1969, passed a bill assessing additional "dues" of \$100.00 per member payable by Sept. 15, 1969, for the purpose of meeting construction costs of the new MAG building, with the threat of suspension for non-payment of this assessment by the date stated above;

WHEREAS, the Randolph-Stewart-Terrell County Medical Society considers this additional assessment of dues to be grossly excessive and radical;

WHEREAS, the membership at large of MAG was not polled nor even adequately notified in advance of the possibility of an increase in dues of this magnitude;

WHEREAS, this assessment could have been spread over several years rather than a period of less than four (4) months;

WHEREAS, good business management and prior planning far in advance could have obviated the large assessment by securing adequate long-term financing;

NOW, THEREFORE, BE IT RESOLVED AS FOLLOWS:

1) This Medical Society hereby expresses its disapproval and protest of the action of the House of Delegates of the Medical Association of Georgia in assessing additional dues in the amount so stated, and in the manner so stated, and admonishes the House of Delegates not to take any such action in the future without a referendum of the bill to the full MAG membership.

2) The Randolph-Stewart-Terrell County Medical Society urges that the House of Delegates immediately revoke the bill referred to in the first WHEREAS clause of this resolution, and pass less radical legislation in this regard.

3) The Randolph-Stewart-Terrell Medical Society strongly recommends to MAG that a questionnaire be mailed to all members of MAG soliciting their individual opinions regarding this matter.

4) The Randolph-Stewart-Terrell Medical Society shall deliver a copy of this resolution to the President of the Third District Medical Society with the recommendation that that Society adopt this or a similar resolution, to be appropriately presented to the proper authorities of MAG.

5) A copy of this resolution shall be presented to the President of the MAG and to the Editor of the *Journal of the Medical Association of Georgia* with the recommendation that it be published in the next issue of that publication.

6) The Randolph-Stewart-Terrell Medical Society wishes to make it clear that we did not and do not oppose the building program, and we do not oppose paying our fair and *reasonable* proportionate share of necessary expenses entailed therein; we do object, and strongly, to the abrupt manner and unrealistic extent of an additional assessment of mandatory "dues," payable over a period of ridiculously short duration; and to the rudeness of the threat of suspension without any adequate prior notification.

ACTION:

The above resolution was presented to the Randolph-Stewart-Terrell County Medical Society at the regularly scheduled monthly business meeting at Metts' Lodge, Dawson, Georgia, on July 15, 1969; upon motion, the resolution was adopted as written, by unanimous vote.

Signed,

DR. EARL MAYO, *President*

DR. JOHN BATES, *Sec.-Treas.*

Editor's Note: Neither the Editor nor the Publications Committee of the Medical Association of Georgia is authorized to take any action which would be in conflict with the wishes of the duly elected House of Delegates, the Council or its Executive Committee.



THE GENERALIST AND THE SPECIALIST

JOHN P. WILSON, M.D., *Atlanta*

THE PRIMARY REMEDIABLE OBSTACLE in successful cancer control continues to be the failure to diagnose the disease and institute therapy early. The subject is a much belabored one and yet physicians still bear a large part of the responsibility, either because of unwillingness or inability to make the effort necessary in both utilizing available diagnostic techniques and participating in the public education concerning self protection against incurable cancer.

It would be less than candid to imply that there is a simple solution to this problem. It is quite complex and there are many obvious difficulties to overcome, including (1) the lack of a mechanism to effectively reach all population groups, (2) difficulty in motivating the layman to avail himself of diagnostic procedures, (3) the inability to diagnose many cancers at a curable state even under the best of circumstances, (4) the feasibility of physicians applying accepted and recommended procedures to the entire population. And, not the least, a sincere question within the profession itself of the practical limitations of some of these diagnostic procedures, which constitutes a reasonable difference of opinion.

While the professional education program of the American Cancer Society has always aimed at all physicians in every area of patient care, the primary emphasis in early diagnosis has been directed to the general practitioner or primary physician. It has been felt that this is the area that could provide the greatest improvement in early diagnosis as this has been the man most likely to see the patient initially.

In approaching the problem of professional education, however, several factors are becoming more apparent. First, there has been a significant change in the ratio and relationship of primary physicians to specialists. In some metropolitan areas there are few general practitioners and frequently the function of the primary physician is assumed by several specialists or subspecialists. This relative increase in specialists and decrease in general practitioners emphasizes the incumbency upon all physicians in all areas of practice to participate in the area of general cancer control. It is logistically impossible to begin to implement any effective cancer control program without this participation. Secondly, in his "dis-membering" by specialists the patient has lost the protection of the overall perspective provided by the generalists. Many cancers are overlooked in patients who are being actively treated by specialists for some specific problem. Even the requirements for a complete examination in hospitalized patients have failed to provide adequate protection. Some physicians have apparently either failed to learn or have forgotten how to do a complete examination, and the recorded physical resulting from a cursory examination is hardly meaningful. It may, in fact, provide a hazard in the form of a "false sense of security" on the part of the patient who may think

that he has had an adequate detection examination. We must take our education program to the specialist as well as to the generalist.

Because no physician is infallible, self appraisal and criticism must come from ourselves. We must recognize that the physician who, in his intentness to treat a particular problem with a patient, allows a lethal and yet potentially curable lesion to progress to incurability will not improve the medical profession's image in the public eye, its posture concerning the demands of governmental agencies, nor equanimity with its own conscience.

340 Boulevard, N.E.

MEDICAL SPECIALTY PROGRAM GRADUATES TWO STUDENTS

The Medical Specialty Assistant Program at Grady Memorial Hospital graduated two more students in August, 1969.

The Medical Specialty Assistant is trained in practical and technical aspects of patient care in Medical Coronary Intensive Care Units.

Upon certification from Grady Memorial Hospital in Atlanta, the assistant enhances the medical nursing team. He is skilled in the mechanical operation of equipment used in Intensive Care Units. He can recog-

nize cardiac arrhythmias and make observations about patient progress. He is proficient in general nursing care and can perform such procedures as minor suturing, laboratory tests, cardio-pulmonary resuscitation, and defibrillation.

Specific information about the graduated students can be obtained from Ann Flewelling, MSA Nurse Coordinator, Medical Specialty Assistant Program, Grady Memorial Hospital, 80 Butler Street, S.E., Atlanta, Georgia 30303.

PEDIATRIC SOCIETY TO MEET

The Annual Scientific Session of the Georgia Pediatric Society will meet October 9, 1969 at the Progressive Club in Atlanta for an all-day session starting at 9:00 a.m.

Guest speakers and their subjects will be:

1. Dr. Mildred Stahlman, associate professor of pediatrics, Vanderbilt University School of Medicine: "Coagulation Studies in the Newborn" and "Respiratory Problems in the Newborn."

2. Dr. Harry Rosenwasser, emeritus professor of otolaryngology, Mt. Sinai Hospital, New York City:

"Management of Ear Infections" and "Management of Hearing Problems in Children."

3. Dr. Warren Wheeler, professor and chairman, department of pediatrics, University of Kentucky: "Ladies' Streptococci in the Nursery" and "An Approach to Children Who Fail to Thrive."

Officers of the Georgia Pediatric Society are as follows: President Dr. LeRoy Antrobus, Atlanta; President-elect Dr. A. J. Kravtin, Columbus; Vice President Dr. Howard Williams, Macon, and Secretary-Treasurer Dr. Jerome D. Berman, Atlanta.

MEDICAL SCHOOLS GET FEDERAL FUNDS

Emory University School of Medicine and the Medical College of Georgia are among 103 schools of medicine, osteopathy, dentistry, optometry and podiatry to receive a total of \$32,364,000 in Federal grants.

The funds were awarded under the health manpower legislation as "special improvement grants" which are intended to help schools to strengthen their curricula, develop new courses, improve teaching

methods, and otherwise increase the quality of their instruction. The grants are intended also to assist schools with serious financial problems to maintain their programs.

Emory University received \$263,600 in new awards, while the Medical College was granted a \$171,292 continuation of funds.



EXERCISE AND THE PREVENTION OF CORONARY HEART DISEASE

JOHN H. EDMONDS, M.D., *Augusta*

IN THE UNITED STATES coronary heart disease (CHD) ranks as the greatest threat to life in the adult population. Its etiology is unknown, and multi-factoral causes have been considered. Physical inactivity or lack of exercise is considered by many as a predisposing cause. If this is true, what is the evidence that a regular vigorous exercise program will aid in preventing CHD? A number of studies indicate that there is a lower incidence and/or prevalence of CHD among men who are habitually more physically active. The big question is: Will an increase in physical activity help prevent or retard the development of coronary atherosclerosis? At the present time there is no concrete evidence that regular vigorous physical activity protects a person from developing CHD. In comparing highly active groups with sedentary ones, many important differences (including heredity) are usually found between the groups in addition to the amount of physical activity. The typical middle-aged businessman tends to be sedentary, overweight, live in a state of chronic "tension," smoke heavily, and eat a diet that is rich in saturated fats. A person who is physically active may have different dietary habits from sedentary people, or he may have more time for recreation and not live under as much chronic "tension." Population studies in which the amount of muscular work is the only variable are needed, but these are extremely difficult to conduct. Although the effect of chronic vigorous exercise on the atherosclerotic process is not known, there are certain physiological and psychological advantages which make regular exercise desirable. "Spin-off" effects of chronic exercise may tend to reduce other risk factors such as obesity, smoking, anxiety, and serum cholesterol and, thereby, be beneficial.

It should be emphasized that the average American male has definite evidence of coronary atherosclerosis by age 20 years; consequently, any preventive measure should begin before then. The current popularity of exercise programs throughout the country is accelerating. However, a word of caution is needed because a number of unexpected deaths have occurred among participants. Any person entering an exercise program should be in good health, use good judgment, and only gradually increase his exercise levels. Probably all people over age 40 should be thoroughly evaluated and advised by their physicians before undertaking vigorous exercise programs. All groups conducting exercise programs (YMCA, health clubs, etc.) should have an advisory board which should include a physician knowledgeable in this field.

The use of exercise in the management of patients with known CHD (i.e. angina, old myocardial infarctions, etc.) seems promising but is an entirely different subject and will not be discussed here.

If the exercising individual utilizes good judgment and adheres to his physician's advice, it seems that chronic exercise is both reasonable and desirable in light of the currently available medical information.

Medical College of Georgia

Prepared at the request of the Committee on Professional Education of the Georgia Heart Association.



NEW DECISION ON INSANITY

JOHN L. MOORE, JR., *Atlanta**

ON FEBRUARY 12, 1969, the United States Court of Appeals for the Fifth Circuit handed down the important decision of *Blake v. The United States*. Because of the importance of the case all 12 circuit judges of the circuit heard the argument and participated in the decision written by Judge Griffin Bell of Atlanta. Decisions of the Circuit Court of Appeals for the Fifth Circuit govern all cases in federal courts in the states of Georgia, Florida, Alabama, Mississippi, Louisiana and Texas. Thus, unless reversed by the Supreme Court of the United States, the law has now changed on the question of the defense of insanity in federal criminal cases arising in Georgia.

Facts of the Case

Blake came from a well-to-do background, had two years of college, and served on active duty with the Navy in the second World War. In 1944, at the age of 21 and while in the Navy, he suffered an epileptic seizure and was thereafter given a medical discharge. He received electro-shock treatment in 1945, and following further mental difficulties in 1945 and 1946, entered a Veterans Administration hospital for a stay of two to three months in 1946. He taught school and coached for a time in 1946. He married in 1947 and three children were born in the ensuing years of that marriage. He was employed by his father in the construction business. Meanwhile, he became a heavy drinker.

In 1948 Blake was admitted to a private psychiatric institution in Connecticut where he remained for some two months and then returned to Miami to work for his father again. He thereafter received private outpatient care from psychiatrists, and between 1948 and 1954 spent time in at least three private psychiatric institutions and received further electro-shock treatment.

By 1954 Blake had left his father's business. From 1955 to 1960 his behavior was characterized by heavy drinking and irrational acts. He began the use of stimulants and drugs. In 1955 he received eight electro-shock treatments. He was adjudged incompetent in 1956 and placed under his father's guardianship to be placed in a private institution in lieu of commitment.

Blake was divorced from his first wife in 1958 and married again shortly afterwards. He was arrested in 1959 for shooting his second wife. After spending a few days in jail he was placed in a state mental hospital for several months and was finally placed on probation for the shooting offense. He continued to receive private psychiatric treatment, in and out of hospitals, while on probation up to the spring of 1963. He spent six months in 1962 in a Florida state mental hospital after being declared incompetent and certified for treatment.

Blake was sentenced to Florida State penitentiary in 1963 after being called up for violation of probation on a charge of aggravated assault. He was released from

* Mr. Moore is a member of the firm of Alston, Miller & Gaines, General Counsel to The Medical Association of Georgia. This article is prepared at the request of The Medical Association of Georgia.

prison on September 14, 1965. While in prison he was hospitalized three or four times, saw the prison psychiatrist, and complained of blackouts. During this period of jail he was divorced by his third wife. He married his fourth wife on December 2, 1965.

As the court said:

"To this point Blake's adult life had been one long round to confinement for mental problems and drinking when not confined."

Facts of the Robbery

The robbery in question occurred on December 6, 1965. Blake was registered at a Jacksonville, Florida hotel. On the particular day he had tried to obtain a legal hearing before the United States District Court in Jacksonville in connection with relief he was seeking from certain state prison restrictions which kept him from going to the Miami area. Blake obtained a hotel employee as a chauffeur for the purpose of driving him about town. He stopped by a bar en route to the robbery, had several drinks and told a waitress that he would be back later with a large sum of money. The waitress jokingly asked him if he planned to rob a bank. He said, "That's possible." Blake robbed one of a number of banks which he claimed had mishandled a trust which was established either by or for him several years earlier. His quarrel with the bank over the trust had gone on for some years and was bitter. He simply selected the bank, ordered his driver to take him to the bank and wait, walked in during rush hour, demanded the money, obtained it, and walked out.

The Trial

There was psychiatric testimony that Blake was suffering from the mental disease of schizophrenia, marked with psychotic episodes, and that his behavior on the occasion of the robbery indicated that he was in a psychotic episode. There was conflicting psychiatric testimony for the prosecution that Blake had a sociopathic personality and was not suffering from a mental disease.

The district court, trying Blake's case, instructed the jury on the basis of earlier decisions of the supreme court of the United States and of the United States Circuit Court of Appeals for the Fifth Circuit. These instructions amounted to the old rule of law in the United States that if the defendant, at the time of the act with which he was charged, knew the difference between right and wrong, he should be considered guilty.

New Standards

The Circuit Court of Appeals reversed the conviction of Blake for robbery in the Trial Court. The court unanimously adopted a new standard, one earlier proposed by the American Law Institute model penal code. That standard requires the court to instruct the jury:

"(1) A person is not responsible for criminal conduct if at the time of such conduct as a result of mental disease or defect he lacks substantial capacity either to appreciate the wrongfulness of his conduct or to conform his conduct to the requirements of law.

"(2) As used in this Article, the terms 'mental disease or defect' do not include an abnormality manifested only by repeated criminal or otherwise antisocial conduct."

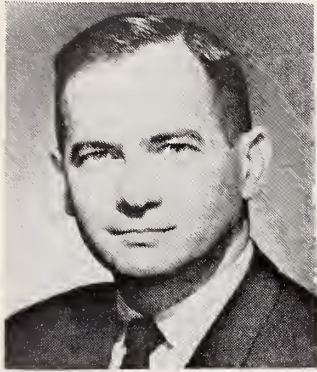
The importance of this decision in criminal cases cannot be over-emphasized. The new standard adopted by the Fifth Circuit Court of Appeals opens the way for a modern approach to this troublesome question.

*Suite 1220
C&S Bank Building*

GAMPAC SETS WORKSHOP FOR OCTOBER 11

ON SATURDAY, OCTOBER 11, GaMPAC will unveil its second biennial Workshop on political education at the Sheraton-Biltmore Hotel in Atlanta. The Workshop will begin at 1:00 p.m. and adjourn at 5:00. The purpose of the Workshop will be to inspire and instruct the members of the profession to achieve a more aggressive and effective role in citizenship's fundamental obligation—political participation.

Here are the Workshop headliners:



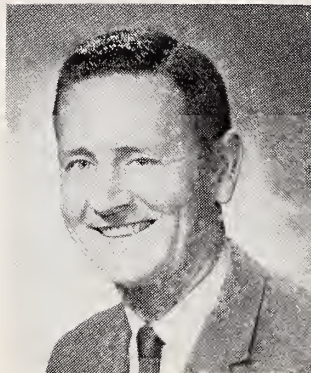
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Comptroller General
State of Georgia



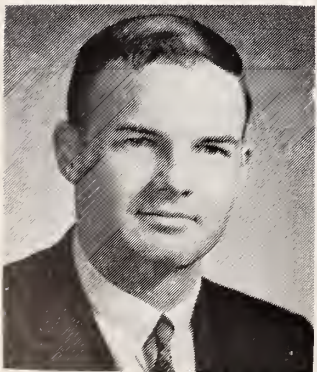
"STRICTLY POLITICS"

Hon. Jimmy Carter
Former State Senator



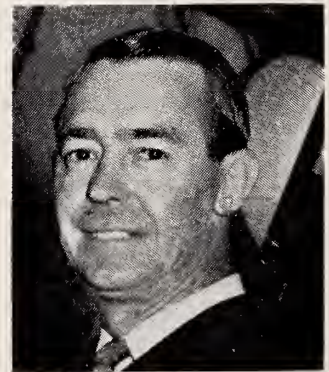
"STRICTLY POLITICS"

Hon. Ed Garrard
State Senator



"STRICTLY POLITICS"

Hon. Carr Dodson, Minority Leader
Georgia House of Representatives



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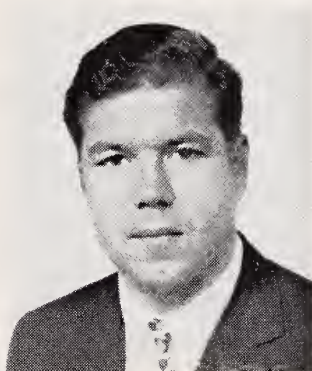
Hal Suit, News Director
WSB-TV, Atlanta



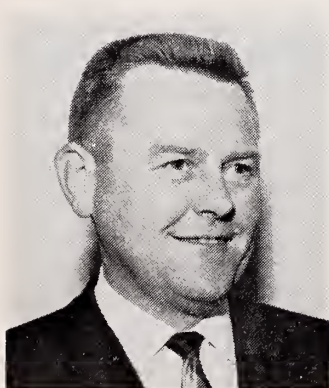
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Fokes, Ernest C., M.D. Active—DeKalb—NS	755 Columbia Dr. Decatur, Georgia 30030
Johnson, Louis M., M.D. DE-4—Fulton—GP	Atlanta Army Depot Forest Park, Georgia 30050
Kleber, Ronald J., M.D. Active—Cobb—P	702 Cherokee Street Marietta, Georgia 30060
Lassiter, Nolan M., M.D. Active—DeKalb—I	1275 McConnell Drive Decatur, Georgia 30030
Patton, William C., M.D. Active—Walker-Catoosa- Dade—Or	700 Dodds Avenue Chattanooga, Tenn. 37403
Stephens, Dan B., M.D. Active—Cobb—OBG	Cherokee Medical Building Smyrna, Georgia 30080
Thibodeaux, David C., M.D. Active—Cobb—R	70 Tower Rd., N.W. Marietta, Georgia 30062

SOCIETIES

The **Whitfield County Medical Society** has announced plans to name Dalton's new speech and hearing clinic for the late John W. Looper, Jr. Before his death, Dr. Looper was instrumental in the preliminary discussions with the Chattanooga-Hamilton County Speech and Hearing Clinic to establish a satellite clinic in Dalton to serve that area.

PERSONALS

First District

Murray C. Arkin and **Lamont E. Danzig** have announced their association in Savannah for the practice of internal medicine.

Curtis Hames spoke before the European Atherosclerosis Group Symposium on "Platelets and the Vessel Wall—Fibrin Deposition," in Frankfurt, Germany, in June.

Henry Wilder Smith of Swainsboro has been re-elected to active membership in the American Academy of General Practice.

Second District

Thomas F. Lear, Jr., following the completion of a four-year residency in surgery at Piedmont Hospital in Atlanta, has moved to Thomasville, where he will practice general surgery.

Fourth District

Edward T. Arnold, Jr., has been awarded a Certificate of Merit by the Dictionary of International Biography of London, England. The award is "for distinguished service as a contributor to medical journals." Specifically mentioned was an article entitled, "Some Fundamentals of Geriatric Practice," published in "Problems of the Aged."

Fifth District

William M. Lester of Atlanta was one of four U.S. physicians whose comments on post-natal examination of the mother were included in the July 14 issue of *Modern Medicine*.

Alfred A. Messer presented a paper entitled "How Does a Family Preserve Its Equilibrium?" at the 118th Annual Meeting of the American Medical Association in July.

Sixth District

Captain Marion L. Ferrell was cited by Brigadier General Daniel K. Edwards, Commanding General of the 30th Infantry Division of the Army National Guard, for his "exceptional display of professional performance" during a severe storm at Fort Stewart, Ga., in July. During the storm, Captain Ferrell treated 80 men for injuries resulting from electrical shock.

The **Chatsworth Medical Center** has terminated its medical services, as its doctors have relocated. Willard Carson has assumed residency in surgery at Georgia Baptist Hospital, and Thomas Carey has assumed residency in pediatrics in Jackson, Miss.

Ninth District

A portrait of **P. K. Dixon**, Gainesville physician and member of the State Board of Health, was unveiled at the July meeting of the Board in recognition of his two-year service as chairman of the health group.

Tenth District

Louis Cacchioli, chief of staff of Hart County Hospital, has been re-elected to active membership in the American Academy of General Practice.

Dr. and Mrs. W. G. Elliott attended the Irish International Medical Seminar at Tralee, Ireland, in July.

DEATHS

Frank Austin Blalock

Frank Austin Blalock died July 8 in a Rome hospital after a brief illness. He was 70 years old.

Dr. Blalock took his residency at Children's Hospital and Bellevue Hospital in New York City, and at the time of his retirement, was director of medical research at Battey Hospital. He had previously worked in the Battle Hill Sanitarium in Fulton County.

He was a member of the First United Methodist Church of Rome, a member of the American Medical Association, Georgia and Floyd County Medical Associations, a member of the Rome Elks Club, Rome Shrine Club, Yaarab Temple of Atlanta, and Masonic Lodge 96 F. and A.M. of Atlanta, Coosa Country Club and the Low 12 Club.

Dr. Blalock is survived by his widow, the former Gladys Edna Melvin; one brother, J. L. Blalock of Calhoun; two nieces, Miss Alice Blalock, of Atlanta, and Mrs. Robert Kite, of Decatur; two nephews, Roy Blalock, of Calhoun, and Doyal Blalock, of Memphis, Tenn.

William Perrin Nicholson

William Perrin Nicholson, former chief of staff at

St. Joseph Infirmary, died July 12 in an Atlanta hospital.

He was a graduate of the University of Georgia and the College of Physicians and Surgeons at Columbia University. He had practiced in Atlanta since 1919.

Dr. Nicholson was a member of All Saints Episcopal Church, the Ansley Park Golf Club, was on the board of the Red Cross, and past master of the Palestine Lodge F. & A.M.

He was a member of the Fulton County Medical Society, the Medical Association of Georgia, the American Medical Association, the Southern Society of Clinical Surgeons, the Southern Surgical Association, and served in the medical corps during World War II.

He is survived by his widow, the former Elizabeth Tuller; his son, William Perrin Nicholson, III, M.D., of Atlanta; sister, Carolyn Nicholson of Atlanta; brother, Larry Nicholson of Atlanta, and two grandchildren.

HIGHLIGHTS OF THE AMA HOUSE OF DELEGATES MEETING

The AMA House of Delegates meeting in New York, held in conjunction with the 118th Annual Convention of the AMA took many important actions on a wide variety of subjects. This report is a summary only of the more important items from that meeting.

The AMA House of Delegates considered and acted upon a record number of items of business at the 1969 meeting in New York City. Business presented to the House included 59 reports from the Board of Trustees, the Executive Vice President, standing and special committees, and 137 resolutions, for an all-time record number of 196 items of business. In addition it heard addresses from Vice President Spiro Agnew, and Dr. Roger O. Egeberg, Assistant Secretary of the Department of HEW for Health and Scientific Affairs.

Of particular importance to the Medical Association of Georgia was the election of Dr. J. Frank Walker to the position of Vice Speaker of the AMA House of Delegates.

Osteopathy

In response to an action taken by the House at the 1968 Clinical Convention, the House voted to amend the Constitution and Bylaws to provide for full, active AMA membership for osteopaths under the following conditions: "... who hold an unrestricted license to practice medicine and surgery, and are entitled to exercise the rights of membership in their state medical associations, including the right to vote and hold office, as determined by their state medical associations."

Medicare and Medicaid

In connection with reducing medicaid costs, the House adopted a report listing four action programs of the profession: expanded peer review programs by county medical societies to reduce hospital and nursing home care and to expand ambulatory care; eradication by the profession of isolated abuses by physicians; promotion of innovative health service delivery systems for low income communities, with emphasis on ambulatory care; and programs by local medical societies to preserve quality of care in the face of cost containment measures.

With respect to physician payment in teaching situations, the House resolved that the Board of Trustees "take action to evaluate and effect improvement of the regulations in keeping with the intent of Medicare and Medicaid in relation to teaching situations."

On the subject of medicare fees and fee schedules, the House said, "While the AMA has not taken a specific position on the procedures relating to the development and application of physicians' fees profiles and prevailing charge screens, the actions which have been taken by the House would indicate that these concepts as defined through directives of the Social Security Administration, are not consistent with policies of the American Medical Association."

The House also said that since "actions taken by DHEW to set rigid limits on levels of payments to physicians who provide services under Medicaid appear in contradiction to Congressional intent that Medicaid patients receive care on the same basis as private patients," it resolved that the AMA "urge a reassessment by Congress of its intent and priorities in relation to Title XIX."

Regarding the isolated abuses of government programs, the House resolved that the Board's "efforts to obtain access to information referable to alleged misuse of any programs of health care be commended" but added that "in the publicizing of charges without the availability of reasonable and specific facts concerning individuals, the result is detrimental to the best interests of American medicine."

Voluntary Health Insurance

The House adopted a report urging that state medical associations, county societies and physicians individually direct "unstinting effort" to promote the proposed program of income tax credits for financing health care and "publicize the advantages inherent in this approach to preserve and strengthen the voluntary system."

Delegates also resolved that the AMA "encourage the development of prepayment medical insurance programs in which the payment to the physician is based upon the usual, customary or reasonable fee concept"

HIGHLIGHTS / Continued

and that "any reference to 'paid-in-full' coverage clearly identify those services which are indeed covered on a 'paid-in-full' basis and also identify the circumstances under which those services must be rendered."

Billing Procedure

"To ensure the continuance of the one-to-one physician-patient relationship," the House stated, "the profession considers direct billing preferable—identifying Medicare primarily as a financial aid to the patient. As long as Medicare holds to a realistic assessment of 'reasonable charges,' there will be comparatively few instances when direct billing entails greater out-of-pocket payment by the patient than does assignment."

Medical Care as a Right

To make its position clear in the long-standing discussions of medical care as a right, the House resolved that it "reaffirm its position (1) that it is a basic right of every citizen to have available to him adequate health care; (2) that it is a basic right of every citizen to have a free choice of physician and institution in the obtaining of medical care; and (3) that the medical profession, using all means at its disposal, should endeavor to make good medical care available to each person."

Extended Care

Because of the higher cost of hospitalization, the House resolved that the AMA "be urged to seek changes in the medicare law to allow direct admission to ex-

tended care facilities when eligible patients' conditions require less than acute hospital care."

Health Care of the Poor

The House adopted the report of the Board of Trustees' Committee on Health Care of the Poor, which reiterated "our strong commitment toward expanding nationwide programs to improve the health of the poor" and stated that "the same quality of medical care should be accessible to all people."

The committee listed "certain concepts that we believe must be included in the Association's program": (Paraphrased and condensed.)

1. Providing comprehensive health care to the poor is a desirable goal.
2. It must be a continuing program, identifying both short-range and long-range activities.
3. The committee's purpose must be to implement the research that has been done on unmet needs for health services.
4. Program must provide for participation of the poor in planning projects for their communities.
5. Physicians should work with numerous other organizations, both in and out of the health field, that have expressed concern about improving health care of the poor.

The committee concluded by stating that it "recognizes that the problems for which it hopes to find solutions are too critical and too complex for superficial, cursory answers. It believes that dynamic action in this field must have a top priority in the American Medical Association's activities."



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Physicians and Hospitals

The House resolved that "the AMA Commissioners to the JCAH urge the Joint Commission to insure that that body which carries out the governing function of the medical staff shall be representative of the medical staff, both hospital-based and voluntary, and that this body shall advise the governing board of the hospital on policy regarding medical judgment and skill and on matters relating to the bylaws, rules and regulations of the medical staff."

Full Disclosure of Laboratory Billing

The House adopted a Judicial Council report, "Review of Ethical Considerations Relating to Clinical Laboratories," which ended with this paragraph: "Where it is necessary for the attending physician to bill his patient for services performed by a clinical laboratory, the bill submitted by the attending physician to his patient should state the name of the clinical laboratory performing the services for his patient and state the exact amount of the laboratory charge paid or to be paid by the physician to the clinical laboratory."

Also adopted was the resolution that the "attending physician is entitled to fair compensation for the professional services he renders. He is not engaged in a commercial enterprise, however, and any markup, commission or profit on the services rendered by a laboratory is exploitation of the patient."

Professional Liability

In connection with professional liability, the House adopted the following statements as recommendations of the AMA:

1. That constituent associations "seek the enactment of appropriate state legislation designed to provide a more efficient and equitable determination of malpractice claims and litigation."

2. That state associations, with the help of AMA, "seek the cooperation of hospital associations and third party taxpayers in exploring and developing, if feasible, pilot programs which will provide scheduled benefits for persons injured as a consequence of medical accidents occurring in the delivery of health care, irrespective of fault."

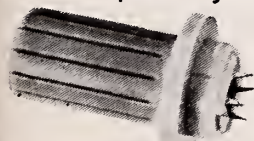
3. "That workshops on malpractice insurance problems be conducted, as requested by the Board of Trustees, in which participation will be invited from (1) physicians confronted by insurance problems, (2) representatives of the insurance carriers, (3) staff attorneys of AMA and other appropriate staff personnel, (4) representatives of and attorneys for the hospital service field, (5) nurses and (6) legislators."

In addition, the House resolved that the AMA "should not attempt to establish a nationwide professional liability insurance program either by sponsorship of a program underwritten by an existing insurance carrier or by seeking to establish a new insurance carrier."

CORRECTION: The correct address for the Allergy Foundation of America is 801 Second Avenue, New York, N.Y., 10017, not 501 Second Avenue, as printed in the April, 1969 issue of the *Journal*.

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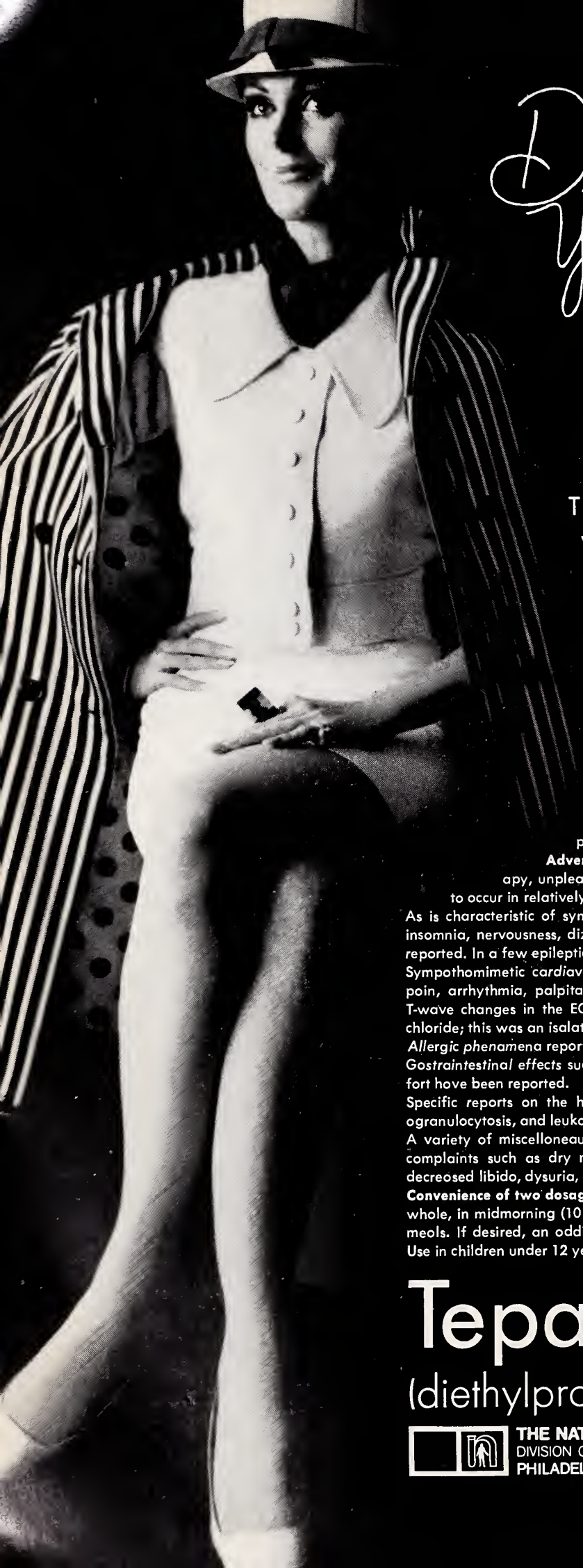
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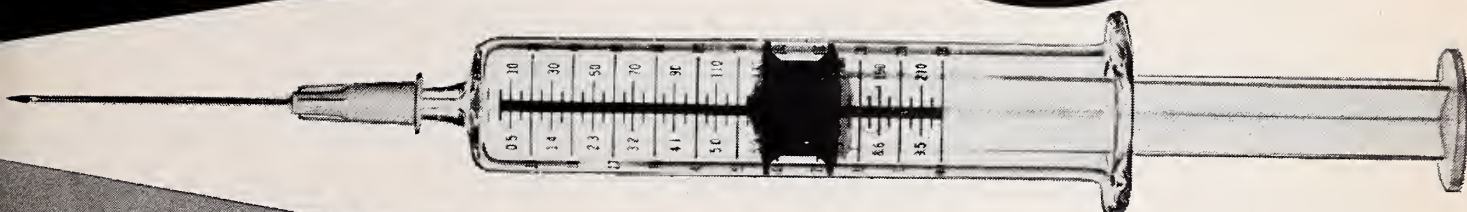
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Cover designed by Marie Seaman.

Special Article

How to Help Your Patient Stop Smoking

DONALD T. FREDRICKSON, M.D., *New York*

MY OBJECTIVE WITH THIS PRESENTATION is to suggest practical guidelines on how to help your office patients stop smoking. What knowledge and understanding I have on this subject derives principally from two sources: (1) my experience over the past three years working with several thousand smokers in public and private withdrawal clinics in New York City and (2) my contacts during this period with a number of distinguished behavioral scientists whose insights I freely admit to having plagiarized without attempts to assign appropriate credits. It should be noted that the withdrawal clinic program that has evolved in New York City is something of a giant mosaic, a composite of dozens of suggestions and flashes of insight, the bulk of which came from cigarette smokers as they worked to gain mastery over this problem.

What do we know, or rather I should say, what do we think we know about the determinants of cigarette smoking and how can the office physician put this understanding to use in guiding smokers who wish to permanently free themselves of this deadly habit? You will note that I refer to smoking as a *habit*. This characterization, I believe, is critical for it helps define our theoretical understanding of "what's going on" and identifies a therapeutic strategy for the smoker that, experience teaches, facilitates the eventual mastery of the smoking problem. For the purposes of this discussion, a habit is defined as behavior one *learns*. Consequently, and here we take a short "leap of faith," it is behavior that can be *unlearned*. I shall make no attempt to distinguish habit from addiction. Addiction is a word that has outlived its usefulness. Indeed, not a few distinguished pharmacologists note that the word has been so badly mauled with so many vague and nonspecific definitions that it is probably beyond salvage for the scientific description of drug effects and, therefore, should be abandoned all together.

For the smoker, defining his problem as an exercise in learning is not only encouraging, it is downright exciting! For if one can learn smoking behavior, one ought to be able to learn its counterpart, nonsmoking behavior. Breaking the cigarette habit then becomes nothing more or less than a matter of retraining. Because we never lose the ability to learn, grow, and change; because we can develop new, more constructive and healthier ways of responding to old situations, one never loses this capacity to be transformed into a permanent nonsmoker. This fundamental premise provides the rationale that gives order and meaning to the welter of tips, hints and suggestions that characterize most smoking withdrawal programs; it is an explanation that seems to make eminently good sense to most smokers; it gives hope to the discouraged and the defeated; and above all, it places the responsibility for stopping squarely where it belongs—on the smoker himself. Because it is the foundation idea on which we base our withdrawal strategy, it is worth restating: Smoking is a habit. A habit is behavior learned through systematic training. Becoming an ex-smoker means one must unlearn the smoking habit and replace it with a newly learned habit—nonsmoking. If the smoker does not succeed with any given effort it is not because he *cannot* succeed; rather, it is because he has not done what is *necessary* for success. He has not retrained himself to be a nonsmoker.

Approach to Smoking

Approaching cigarette smoking as a form of behavior subject to the laws of learning helps strip away much of the confusion and mystery surrounding the habit and identifies the work tasks to be accomplished if one is to have success. As with all learning tasks there are four ingredients in the suc-

cess formula: motivation, insight, practice and attitude. Because of its profound significance the remainder of this discussion will center on motivation and how the physician hastens the process of helping the smoker make the critical decision to do something about his smoking problem.

It is my impression that many physicians are not aware of the substantial body of evidence indicating that most smokers, indeed possibly the great majority, can and will quit smoking if we can get them to do one thing—*stop ignoring the problem*. For, in spite of all the anti-smoking propaganda it is a simple fact that large numbers of smokers manage to survive their daily routines with little if any thought given to the fact that their cigarette smoking constitutes a *serious personal problem*, a problem that they have a responsibility to do something about. I submit that most smokers continue to smoke because they simply don't think about their smoking as a *problem*. How can we move the smoker to sit up and look hard at himself and his smoking problem? As suggested, we are talking here about decision making.

On this score, Dr. Daniel Horn has given us some valuable insights. He observes that there are several categories of reasons that might cause a person to decide to do something about his smoking. Let us take these in order of the probable importance.

Health: To be significant it is likely that smoking as a health threat must be seen in the following light: (a) it is a hazard that is something more than trivial, i.e., it is an *important threat* to health, (b) it is a threat that has *personal relevance*, i.e., "it's not the other guy who's threatened, *it's me!*," (c) it is a threat that I am capable of doing something about, i.e., "I have the *capacity* to stop smoking, should I decide that that is what I want to do," and (d) this is *worth* doing something about, i.e., "if I stop smoking there will be a 'payoff' for me." Other incentives that are important for smokers include:

Example: "My wife and/or my children want me to stop. I will do it for them." **Personal Mastery:** "I am bothered by having lost control over this aspect of my behavior, I am tired of being a slave to cigarettes, I want my freedom back." **Esthetics:** "I've had enough of this dirty habit—I smell bad, look bad, taste bad, and there are burn holes in the rugs, the furniture, and in me!" **Economics:** "A 30-year, two-pack-a-day habit at 5 per cent interest adds up!" (one ex-smoker noted rather pathetically that he could have easily put both sons through college on the money he spent on cigarettes during a lifetime).

The physician, because of the authority and influence of his office, is in an absolutely unique position to help his patient find the incentive(s) for stopping that are important and right for him. And yet there is disturbing evidence that doctors are not fulfilling their responsibilities in this area. A recent Public Health Service survey¹ of physicians demonstrated that while the overwhelming majority of doctors polled (77 per cent) agreed with the statement: "It is the physician's responsibility to attempt to convince his patients to stop smoking," and an even larger proportion (86 per cent) agreed that: "If a patient wants to stop smoking, it is the physician's responsibility to help him accomplish this," only 38 per cent of physicians said that they regularly advise all or almost all of their patients to quit or cut down on their smoking. Why are we missing this unparalleled opportunity to practice such effective preventive medicine? In many instances I suspect it is because the physician himself has become discouraged. For one reason or another he has simply concluded that just talking about cigarette smoking will have little if any permanent effect on his patients' smoking behavior.

Again, and one really cannot emphasize this too forcefully, there is abundant evidence that many cigarette smokers, possibly most smokers, can and will give up smoking if we can just get them to pause and take a good hard look at the facts about smoking and the implications of these facts for their continued health and well being. It is astounding to realize that the simple suggestion from one's personal physician that the patient should and can stop smoking may be all that is needed to begin the process of decision-making that will eventuate in a complete and final break with the habit. Here are a few practical suggestions on ways to communicate with the patient on this issue.

What better place to begin than the waiting room? As a starter, why not remove the ashtrays or, better yet, fill them with cigarette substitutes such as paper clips or small bite-size pieces of non-caloric candy? This in addition to carefully selected literature² on smoking (available through the Public Health Service) and possibly a few strategically located posters with such messages as: NO SMOKING—CANCER CONTROL IN PROGRESS, or the Public Health Services': ONE HUNDRED THOUSAND DOCTORS HAVE QUIT SMOKING CIGARETTES—MAYBE THEY KNOW SOMETHING YOU DON'T (clearly the soft sell) may suggest to one's more observant patients that this physician apparently feels rather strongly about cigarette smoking. You see, you can

begin communicating the minute the patient crosses the threshold.

Second Step

A second step would be to incorporate a detailed review of the patient's smoking behavior in the history form or, as some physicians have done, develop a separate one-page history on smoking that is handed to every new patient by the receptionist or the office nurse—again its very presence suggesting the importance of the subject to the doctor.

Now we have the patient in the examining room, undressed and waiting to meet the physician for the first time. Here is an opportunity to suggest and reinforce the message that should never be missed. One physician of my acquaintance has his office nurse hand each patient a pamphlet on smoking while he sits undressed waiting in anticipation for the doctor to appear. On leaving the room she has been instructed to remark casually, "Better read that, the doctor always asks his patients about its contents!" So far we haven't taken a moment of the doctor's time. Enter the physician.

From this point forward the opportunities for communicating the message to the patient will be limited only by the imagination and ingenuity of the physician. The objective is to establish the *personal relevance* of the cigarette habit for that patient and at the same time establish the point that because smoking is a habit it can be conquered. Here are a few random thoughts on how this might be accomplished.

Effective Argument

In making the presentation it has been our experience that one of the most effective arguments for stopping rests with the increased risk the smoker takes of being *prematurely disabled* at mid-life from one of the cigarette-associated chronic diseases. While it is certainly legitimate to refer to increased cancer, the idea that in quitting smoking you significantly lower the odds of *early crippling disability*—disability in the 30's, 40's, and 50's—seems to have a special significance particularly for the young smoker with a growing family and enlarging professional and community responsibilities. I have often heard smokers remark: "Really, the thought of death doesn't bother me. It seems so far away and, after all, you've got to die of something, you can't deny that. Besides, I calculate my chances of developing lung cancer to be relatively small. But the thought that I might have to spend 15 or 20 years during my prime with a crippling disability that interferes with the enjoyment of living and reduces my ability to function, that's too much! Smoking just isn't worth it!"

Another point worth emphasizing, one with particular impact for the patient approaching his 50's and 60's, is that irrespective of how long or how much one has smoked, one has everything to gain by stopping now. A man with a 30-year habit on his back may simply rationalize his continued smoking by saying: "The damage is already done, there's nothing for me to gain (i.e., no 'payoff') by stopping now." I have been absolutely astonished at how often even very intelligent smokers utilize this justification to continue smoking and respond with surprise and at times almost with childlike amazement to the knowledge that even if one has smoked heavily for many years and stops, the injury caused by smoking stops and because of the body's amazing recuperative powers a substantial amount of the damaged tissue may be restored.

Another matter to stress with all patients is the immediate effect of smoking on the body, i.e., the message here is that no one escapes injury. If the patient can come to appreciate that each drag on his cigarette is something of a body blow to several of his delicate biologic mechanisms one can often heighten this sense of personal relevance of the health threat. On this score two approaches suggest themselves. The physician can frequently make a direct connection between the patient's symptoms and his cigarettes, i.e., cough, morning phlegm, draining sinuses, shortness of breath, midday fatigue, etc. Respiratory symptoms in particular can be legitimately and quite effectively tied to the cigarette habit. I might add, parenthetically, that it often surprises us how many of these symptoms subside, or disappear altogether when the patient stops smoking.

Powerful Reinforcement

Simply pointing this out will often serve as a powerful incentive to stop as well as reinforcement of the patient's determination to remain cigarette free. Many patients have told me that the reason they do not go back to smoking is simply because they "feel so good" when they are not smoking. The physician can also give a brief description of the action of smoke on the muco-ciliary apparatus, stressing the importance of the cilia as the principal cleansing mechanism of the respiratory tract. The knowledge that each puff works to paralyze the delicate hairlike structures so vital to the body's well-being will powerfully impress many smokers. Some patients even begin suggesting to themselves such provocative thoughts as: "Just taking this one puff is doing actual physical harm to my body—those poor delicate, defenseless little cilia of mine, paralyzed because of my cigarette habit!"

At this juncture let us pause to reemphasize what physicians know so well, to wit: that when the pa-

tient comes to the doctor for that first visit he is often in an unusually receptive and suggestive state, particularly regarding matters concerning his current health status. He may present with a specific symptom or constellation of symptoms that are troubling him deeply, symptoms as we have already noted, that may be linked in a powerfully effective way with his smoking habit. One physician of my acquaintance never misses an opportunity to do just that. In fact, he reserves his most pointed questions about smoking for his examination of the chest. As he stands behind the patient listening through his stethoscope he solemnly inquires: "How much did you say you smoke? For how long? Hmmm, cough again please!" He tells me that this little drama in association with a brief, low-keyed talk on smoking accompanied with his admonition to stop smoking is all that is needed to start many patients on the road to a smoke-free existence. Regrettably, I fear, physicians all too often miss these unique opportunities to deliver the smoking message when the patient's receiving apparatus is operating at maximum sensitivity. Let me give two examples from my own personal experience. Both involve middle-aged business executives. Their stories are clearly instructive.

The first concerns a young chap in apparent good health living with a pressure-cooker job and smoking three and one-half packs of cigarettes a day. By his own admission he had read a summary of the Surgeon General's 1964 report on smoking and health and had temporarily reduced his cigarette consumption. In short order he was back to his normal rate. As he put it: "I somehow had the feeling that this just didn't apply to me. After all I've always considered myself to be in excellent physical condition and even though I smoked heavily, I have always felt well." Early one morning he was aroused from a sound sleep with extreme chest pain (a spontaneous pneumothorax). This caused him great alarm, almost panic, for his initial impression was that he was having a heart attack. During the emergency room examination the physician casually inquired about his smoking habit and suggested, that if at all possible, he stop smoking. No further elaboration was given. As it turns out none was needed. The patient stopped smoking and has never resumed. That was three years ago. During a recent conversation I asked him why he had stopped. He said he wasn't quite sure but that somehow in his own mind he had connected his smoking with this painfully frightening episode and on reflection it seemed that whatever gratification he was obtaining from his cigarettes just "wasn't worth it." Do you

see what happened? This wise physician simply planted the seed and allowed the patient to make all the other necessary connections. If I may say so, this strikes me as a beautiful example of how a perceptive doctor saw his golden opportunity and made the most of it. One more example, this one to illustrate an opportunity that was missed.

Another Example

Again, it involves a business executive in his mid-30's smoking, in this instance, four and one-half packs of cigarettes a day. I met this gentleman for the first time at a smoking withdrawal clinic. About a year before he had developed a sudden difficulty with vision in one eye. At first he tried to ignore this but as the blurring and color distortion progressed, he became alarmed. He finally submitted to a thorough and lengthy examination by one of New York's leading ophthalmologists. Over a period of weeks with the assistance of local medication his symptoms subsided. On one of his follow-up visits the ophthalmologist and the patient became engaged in a conversation on cigarette smoking. According to the patient, this doctor actually felt very strongly about cigarette smoking, and he encouraged the patient to stop. This was the patient's response: "You know if that physician had even so much as *suggested* that my smoking was in some way related to my eye problem, particularly during the period when I thought I might be going blind, I think, no, I *know* I would have stopped smoking." Now one may argue that this is nothing more than after-the-fact rationalization. But I must say as I heard the tale unfold I could not but conclude that this patient was probably telling the truth. I suspect he would have stopped smoking or at the very least made a herculean effort to stop had he been so instructed, even indirectly instructed, during the height of his crisis. One never knows, of course, but for this physician who felt so strongly about cigarette smoking and in particular for this patient, such an opportunity may not come again.

I indicated at the outset that there were four elements in the formula for success. Motivation—helping the patient find strong incentives for decision making is, in my mind, clearly the most important. For once the smoker has confronted himself and is committed to a determined effort to stop smoking, I submit that at least half of the battle is won. It is my impression that having accomplished this, most smokers will somehow work out their own withdrawal strategy with little additional assistance required other than an occasional reinforcing "pat on the back." There will, of course, always be those who will need additional encouragement, support and guidance. And for those of you who are inter-

ested in a more detailed guideline for managing these individuals, I would refer you to the *Symposium on the Office Management of Smoking Problems*³ that appeared in the September, 1968, issue of *Diseases of the Chest*. In addition, I have recently prepared a booklet⁴ elaborating on the instructional material presented in our five-part television series on "How to Stop Smoking" that will soon be available for distribution through the American Heart Association.

In summary, I would suggest that in counseling patients on cigarette smoking, we, as physicians, have a unique if not unparalleled opportunity to "put our money where our mouth is" and engage in the most highly effective form of chronic disease prevention known to modern-day medicine. Indeed, if every physician would accept personal responsibility to intelligently counsel *all* of his patients on cigarette smoking, I suspect more would be accomplished to curb this serious health menace than through any other single activity—government controls notwithstanding. A skillful program of psychological warfare against the smoking habit can be incorporated into any practice with a minimum of

time and effort and with little or no disruption of the office routine. Because the physician never knows when his message and the smoker will connect he will be constantly challenged and must never become discouraged. Helping patients stop smoking is truly an exciting business. The payoff for both doctor and patient is clearly worth a maximum expenditure of effort. As one successful ex-smoker so aptly phrased it—"The juice is surely worth the squeeze!"

301 East 64 Street

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LEUKEMIA SOCIETY OF AMERICA REVISES RESEARCH GRANT POLICY

Revisions in the research grant policy of the Leukemia Society of America, Inc. were announced today by Dr. John J. Kenny, Society President, and Dr. William Dameshek, Vice President for Medical and Scientific Affairs.

The basic change in the policy is that there will be one grant application review meeting annually in late January. Deadline for submission of grant applications has been changed to November first. Grants approved at the January meeting will be effective the following July first.

"As in the past the Society will continue its support of individuals rather than projects," Dr. Dameshek said. "In awarding more than \$3,500,000 in grants to 192 investigators in the United States and overseas during the past 15 years, the Society has been making a steady contribution to the broadening of the base of knowledge of leukemia. In addition, these grants have played an important role in encouraging outstanding young researchers to choose a career in leukemia, and in effect, to dedicate their lives to the conquest of leukemia."

Types of Grants

The Society awards four types of grants:

Scholar Program—Five year grants totalling \$100,-

000 are awarded to individuals having a doctoral degree (M.D., Ph.D., D.V.M.) who have demonstrated distinct ability in the investigation of leukemia and related disorders.

Fellow Program—Two year awards totalling \$16,000 to promising young investigators having a doctoral degree to encourage work in leukemia research.

"Special" Fellow Program—Two year awards totalling \$21,000 to investigators who have demonstrated ability in post-doctoral research and who have become interested in working in the field of leukemia and related states.

Grants-in-Aid—Annual grants given only in unusual circumstances to encourage new and experimental work.

Applications can be obtained by writing the Vice President for Medical and Scientific Affairs, Leukemia Society of America, Inc., 211 East 43rd Street, New York, New York 10017.

The Society's programs are supported by voluntary contributions from individuals, clubs, business firms, unions and foundations.

The Society's research support, education and patient-aid programs are a direct response to the unique nature of leukemia and the problems relating to its treatment.

Accidental intravenous injection is hazardous because of the possibility of an instantaneous overdose.

Acute Blood Levels of Lidocaine Following Paracervical Block

GEORGE M. CHASTAIN, M.D., *Atlanta*

THE RAPID ONSET OF SOMNOLENCE AND APPARENT COMFORT frequently seen immediately following bilateral paracervical block is usually attributed to "a perfect block." On the basis of this study we suggest instead that this sudden complete analgesia may sometimes be the result of direct vascular entry of the local anesthetic with resultant systemic analgesic and hypnotic effect.

Our attention was directed to the possibility of undetected vascular entry by one patient who grossly convulsed two minutes following bilateral paracervical block with a total of 300 mg. of mepivacaine. Careful syringe aspiration had been carried out prior to injection but blood was not detected.

In order to evaluate the frequency of unrecognized intravascular entry we performed serial venous blood lidocaine determinations following paracervical blocks in obstetrical patients.

Method: Part I

Determination of optimal time for patient venous sampling was obtained in the following manner. A #18 indwelling teflon needle was placed in a large antecubital vein so that without the use of a tourniquet a blood sample could be quickly withdrawn. Three ml. of Evans Blue dye (commonly used for blood volume determinations) was rapidly injected into a vein of the opposite arm. Serial blood samples were withdrawn from the indwelling catheter at 15 second intervals after dye injection. Two patients were utilized; one patient about to undergo a D & C procedure and one labor patient. This technique demonstrates the optimal sample time to detect intravenous injections.

For comparative purposes, a direct intravenous injection of 150 mg. of lidocaine was injected in one surgical patient and samples obtained as above.

Part II

Eighteen patients received bilateral paracervical blocks for Stage I labor analgesia with a total dose of 300 mg. lidocaine. All patients were in a well-established labor pattern and did not have fetal distress or other obstetrical complications.

Paracervical blocks were performed utilizing the Abbott Disposable Cervical Pudendal Injection Set.* These sets are constructed so that the injection needle will extend into the paracervical tissue a standard depth of 1.1 cm. Injections were made corresponding to the three and nine o'clock paracervical positions. Ten ml. of 1.5 per cent lidocaine without a vasoconstrictor was employed on each side so that the total dose was 20 ml. or 300 mg. Five ml. of 1.5 per cent lidocaine was injected simultaneously through the left and right needles and one minute later, an additional 5 ml. of agent was injected. Each injection required five to 10 seconds. The one-minute pause between the first and last half was allowed so as to minimize the possibility of having a 300 mg. bolus IV at one time.

Serial heparanized blood samples were drawn at one, two, four, eight and 20 minutes through an indwelling venous needle as in Part I. The beginning of the initial injection was recorded as time zero. The blood samples were drawn freely without the use of a tourniquet or other venous stasis. An initial sample drawn prior to injection served as the blank. Lidocaine blood levels were obtained for all specimens using a modified methyl orange technique.¹ During and following these block procedures, patients were carefully observed for systemic effects and observations recorded. Fetal heart tones were monitored prior to and for 20 minutes after the blocks were performed.

* This paper received first prize for original research in resident's competition given by the Georgia Society of Anesthesiologists.
Presented at the meeting of the Georgia Society of Anesthesiologists in Savannah, May 4, 1969.

* Courtesy Abbott Laboratories.

Results: Part I

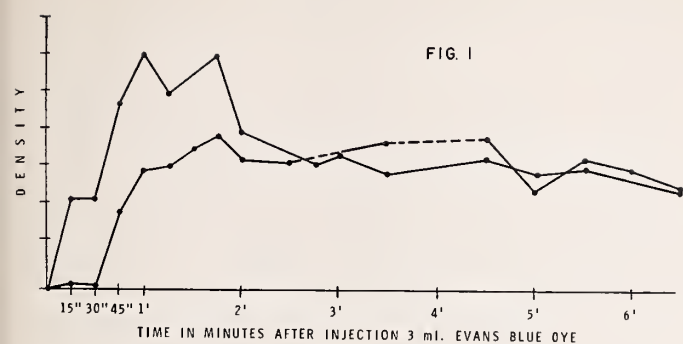


Figure 1 shows the graph obtained after intravenous injection of Evans Blue dye. High concentrations were seen at 45 seconds and by one minute, peak values were obtained. These data suggest that initial sampling at one minute would demonstrate vascular entry if it had occurred.

Part II: Summary of Clinical Results

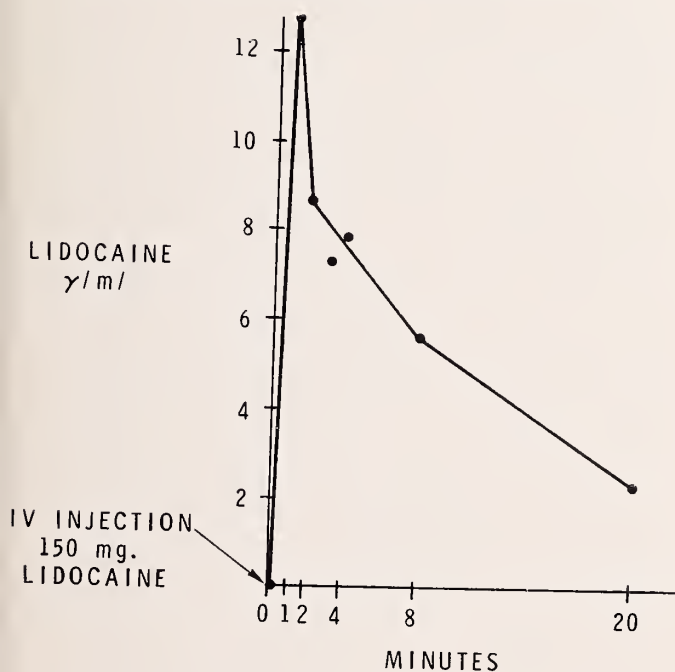


FIG. 2

Figure 2 shows the direct intravenous injection of 150 mg. of lidocaine and the curve obtained using our sampling times and technique.

Figure 3 shows serial blood lidocaine values for three patients who had high peak values at one minute and presumably represent direct vascular entry. Figure 4 includes two additional patients who had high lidocaine peak values at two minutes and most likely also represent direct vascular entry.

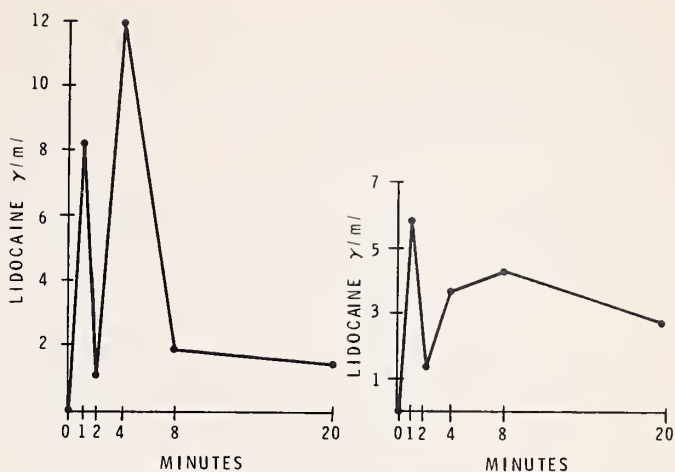


FIG. 3

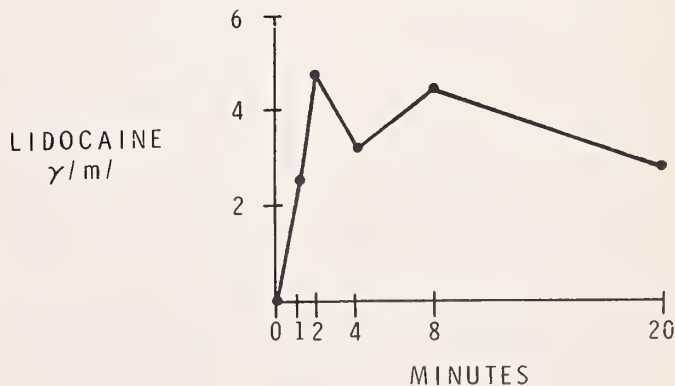
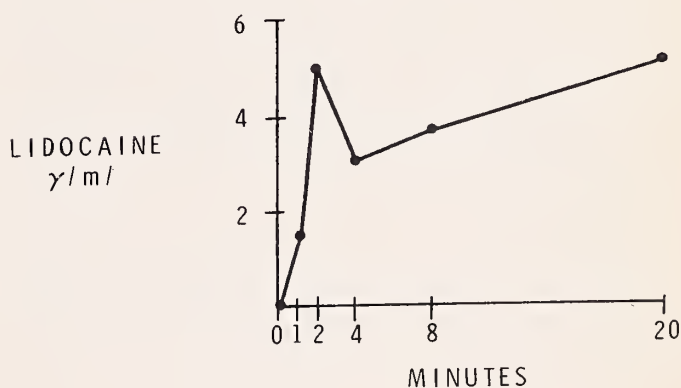
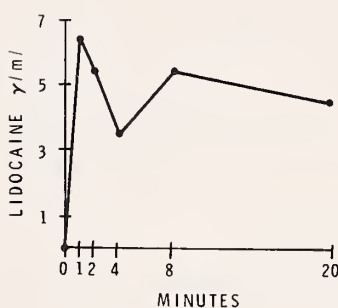


FIG. 4

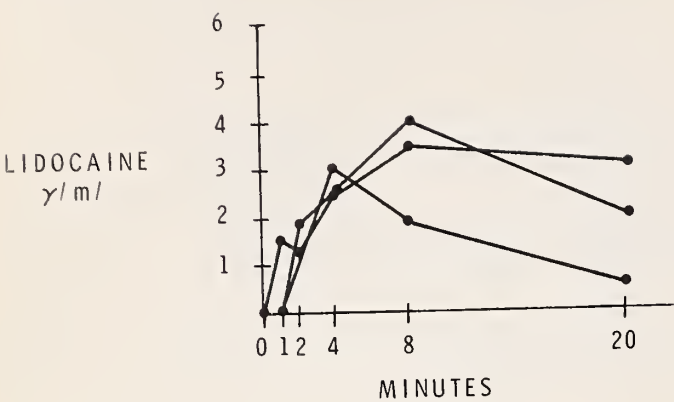


FIG. 5

Figure 5 is a composite of the usually found blood levels in patients where vascular entry has not occurred.

TABLE I

	Patients No. Percent	
1. Satisfactory bilateral block	18	16 88
2. Fetal bradycardia (less than 100/min. and sustained greater than 5 min.)	18	3 16
3. Systemic symptoms (showing somnolence)	18	6 33
4. Apgar depression (7 at 1 or 5 min.)	18	0 0

Systemic symptoms included sudden somnolence, marked shivering, thick speech, facial paraesthesias, and dizziness; the most common being somnolence and shivering. These symptoms are commonly seen following direct intravenous injection of local anesthetics.²

Somnolence was noted in all patients with high initial blood levels. No patient experienced a convulsion or became hypotensive as measured with standard blood pressure apparatus.

Discussion and Conclusions

The use of intravenous local anesthetics, most particularly lidocaine, has been shown to have several beneficial effects. Among these are control of cardiac arrhythmias,³ cough suppression,⁴ systemic analgesia,⁵ and also the use of local anesthetics for IV regional block technique.⁶ All of these, however, are under strictly controlled conditions. The inadvertent administration of a local anesthetic intravenously can have disastrous consequences, the most feared being convulsions or cardiovascular collapse.

The incidence of convulsions during the peripartum period secondary to local or pudendal block

was approximately 1:2469 in one study.⁷ These reactions were due either to a dose in excess of that recommended or “an inadvertent intravenous injection.”⁷

Many factors are important in considering the toxicity of a local anesthetic. Among these are the relative toxicity of the drug itself, total dose, rate of administration, the presence of a vasoconstrictor, and the rate of systemic absorption. In the final analysis, however, the toxic effects are produced only by excessive plasma concentrations. The blood level necessary to produce a toxic reaction is variable. In one study using intravenous infusion, symptoms of toxicity occurred with lidocaine at a blood level of approximately 5.3 mcg. per ml.⁸ Usubiaga, et al.,⁹ however, points out that slow or intermittent intravenous injections reduce the frequency of convulsive reaction as the extra time allows for tissue redistribution and a lower peak blood concentration. A rapid intravenous infusion produces a bolus effect and presents the brain with a very high concentration thereby increasing the frequency of convulsive reactions. Steinhaus¹⁰ states that when lidocaine dosage exceeds 200 or 250 mg. per minute intravenously, the incidence of toxic manifestations such as convulsive phenomena markedly increase.

In this study high peak lidocaine blood levels occurred within one or two minutes of paracervical block injections in five of 18 patients. This would certainly suggest that intravascular entry or its equivalent is a built-in unavoidable hazard of paracervical block analgesia. Vascular entry in our study was not successfully predicted by blood aspiration attempts prior to any of these injections. When vascular entry occurs, analgesia may be due to systemic effects of the local anesthetic. Although lidocaine intravenously in controlled situations is often of therapeutic benefit, accidental intravenous injection is hazardous because of the possibility of an instantaneous overdose. We have proven that this phenomenon does occur frequently with the methods we have employed. This potential hazard warrants a more cautious approach to the paracervical block than is often exercised.

Drug dosages should be held to a minimum and test doses should be frequently employed. A physician utilizing paracervical block analgesia must have a knowledge of local anesthetic toxicity and its treatment, and should have all necessary resuscitation drugs and equipment on hand.

Summary

Inadvertent intravenous injection occurring during paracervical block labor analgesia is a frequent-

ly occurring, but unrecognized complication. The present study was designed to objectively prove through use of serial blood lidocaine determination that this is a real problem. We have herein demonstrated that despite careful aspiration checks intravenous injections do frequently occur (29 per cent) and do in fact constitute a hazard. Systemic effects of intravenous lidocaine and their contribution to labor analgesia have been discussed. From these studies we suggest that concentration and total mass of drug utilized for these blocks be minimized and that the paracervical block be considered a serious matter.

Emory University School of Medicine

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CALENDAR OF MEETINGS

In Georgia

Nov. 7-8—Georgia Academy of General Practice, Marriott Motor Hotel, Atlanta.

Nov. 8-9—American College of Chemosurgery, Hyatt House, Atlanta.

Nov. 10-13—Southern Medical Association, Atlanta.

In the Nation

Oct. 20—American Association of Poison Control Centers, Palmer House, Chicago, Ill.

Oct. 20-24—American College of Angiology, Dunes Hotel, Las Vegas, Nev.

Oct. 22—Conference on Nutrition and Metabolism, Temple University Medical Center, Philadelphia, Penn.

Oct. 23-25—American Academy of Clinical Toxicology, Palmer House, Chicago, Ill.

Oct. 25-26—Midwest Forum on Allergy, Hilton Hotel, Pittsburgh, Penn.

Oct. 25-29—American Society of Anesthesiologists, San Francisco Hilton, San Francisco, Calif.

Oct. 26-Nov. 1—Pan-American Congress of Gastroenterology, Puerto Rico Sheraton Hotel, San Juan.

Oct. 26-30—Medical Library Association, Brown Hotel, Louisville, Ky.

Oct. 28-Nov. 2—American Society of Clinical Hypnosis, Jack Tar Hotel, San Francisco, Calif.

Oct. 29-30—American Association for the Study of Liver Diseases, Sheraton Hotel, Chicago, Ill.

Oct. 30-31—International Tissue Conference, "Blood Cells as a Tissue," Lankenau Hospital, Philadelphia, Penn.

Oct. 30-Nov. 3—Society of Teachers of Family Medicine, Netherland Hilton Hotel, Cincinnati, Ohio.

Oct. 31-Nov. 1—Central Society for Clinical Research, Drake Hotel, Chicago, Ill.

Oct. 31-Nov. 1—Society for the Scientific Study of Sex, Barbizon Plaza Hotel, New York, N.Y.

Oct. 31-Nov. 3—Association of American Medical Colleges, Netherlands Hotel, Cincinnati, Ohio.

Nov. 3-7—American Society of Tropical Medicine and Hygiene, Shoreham Hotel, Washington, D.C.

Nov. 6-7—American Academy of Compensation Medicine, New York University Medical Center, New York, N.Y.

Nov. 6-8—American Society of Cytology, Palmer House, Chicago, Ill.

Nov. 10-14—American Association of Public Health Physicians, Philadelphia, Penn.

Nov. 10-14—American College of Preventive Medicine, Philadelphia, Penn.

Nov. 10-14—American Public Health Association, Philadelphia, Penn.

Nov. 13-18—American Heart Association, Memorial Auditorium, Dallas, Tex.

Nov. 16-20—American Association of Blood Banks, Shamrock Hilton, Houston, Tex.

Nov. 17-21—World Mental Health Assembly, Shoreham Hotel, Washington, D.C.

Nov. 19-23—Academy of Psychosomatic Medicine, Mt. Shadows Hotel, Scottsdale, Ariz.

Nov. 20—National Society for the Prevention of Blindness, Roosevelt Hotel, New York, N.Y.

Nov. 24-26—Conference on "Down's Syndrome," Waldorf-Astoria Hotel, New York, N.Y.

Nov. 29—AMA Medical Services Conference on Medical Review Activities, Denver, Colo.

This condition involving median nerve entrapment may present a puzzling diagnostic problem.

Carpal Tunnel Syndrome— Diagnosis and Management

JAMES L. BECTON, M.D., *Augusta*

THE DIFFERENTIAL DIAGNOSIS OF PAIN in the hand is a long one. Establishing the correct diagnosis as to the etiology is often difficult. It is the purpose of this short paper to serve as an introduction to the carpal tunnel syndrome (median nerve entrapment at the wrist) as a frequent cause which is often overlooked.

The complaints of "numb," "tingling," "sleeping," "painful," feelings in the hand are confusing to most doctors. Patients usually attribute it to "poor circulation," but tell you that their hands "look all right." They may complain that the "whole hand," forearm and, on occasion, the shoulder are involved. By close questioning and further observation it will be found that the little finger is not involved.

Patients will frequently complain of being "awakened at night by my hands going to sleep." They notice that sewing, writing, driving a car, holding cards or any other sustained grasp maneuver brings on the symptoms.

Fingers may feel stiff or swollen, especially on arising in the morning. The symptoms are more frequent in the dominant hand; however, they are often bilateral.

Physical Examination

The physical findings in a patient with a carpal tunnel syndrome are frequently not obvious and only by special physical diagnostic tests will these findings be appreciated. The skin of the hands usually looks normal. There are usually no trophic changes of the hands or fingers. The circulation of the fingers is normal. This often disturbs the patient because his family and friends will tell him "your hands look all right."

Thenar atrophy is present in about half the cases and often it is only minimal. This can best be seen in the hands in the profile view. This atrophy of the

thenar muscles is present only when there has been a long standing median nerve compression.

A positive Tinel's sign at the wrist, over the median nerve, is present in about 75 per cent of the cases. This is characterized by a tingling sensation radiating out into the hand, which is produced by light percussion over the median nerve at the wrist.

The wrist flexion test is done by holding the wrist in marked volar flexion for one minute and it is considered positive when numbness and paresthesias in the median nerve distribution in the hand are reproduced by holding the wrist in the flexed position. The mechanism involved is thought to be that of acute angulation of the median nerve over the proximal edge of the deep transverse carpal ligament.

Tourniquet Test

The tourniquet test is done by inflating a pneumatic cuff (blood pressure cuff) on the arms to a pressure above the systolic pressure for two minutes. Paresthesias may begin in the hand in the region of the median nerve distribution. An irritated compressed nerve is most susceptible to congestion and ischemia.

The sustained grip test is done by holding an object with a tight grip for one minute. If paresthesias begins in the hand in the region of the median nerve distribution, it is considered positive.

A swelling on the volar aspect of the forearm, just proximal to the wrist, is sometimes present and suggests an associated tenosynovitis of the flexor tendons.

An electromyographic study on the median nerve at the wrist will show a delay or latency in the median nerve conduction to the thenar muscles when stimulated above the wrist. The normal is

5 milliseconds; however, the average in carpal tunnel syndrome is 8.4 milliseconds. The electromyograph is often helpful in the differential diagnosis between the carpal tunnel syndrome and an irritation of C-6, C-7 and C-8 nerve roots. Median nerve conduction time of motor impulses may be normal in the presence of an obvious carpal tunnel syndrome or may be slow in a normal patient. Therefore, the diagnosis of the carpal tunnel syndrome or median nerve compression at the wrist is a clinical diagnosis.

X-ray of the wrist in a patient with a carpal tunnel syndrome is usually normal; however, it is helpful to get the routine views of the hand and then do a carpal tunnel view to see if any calcific deposit or any other opaque substance is in the carpal canal.

Treatment

Many patients with an acute onset of the carpal tunnel syndrome will require no treatment and with observation alone the paresthesias in the median nerve distribution of the hand will gradually clear. However, some people are improved by holding the wrist in the position of function with a splint. This in conjunction with diuretics can often be helpful.

Some patients will complain of having paresthesias in the median nerve distribution only at night and that they are awakened by the numbness and tingling. During the day they are able to work and not have any difficulty with their hands. These people can be helped by using a canvas wristlet, which is made with metal stays and velcro fittings to hold it in place. They can use this at night and then remove it during the day. This prevents sleeping with the wrist in the acutely flexed position.

Patients who have had their symptoms for a considerable period may be improved by an injection of 1cc of Hydrocortisone in the carpal tunnel. This is done with a 25 gauge needle on the ulnar side of the palmaris longus tendon.

About half of the patients who have the carpal tunnel syndrome will require having a surgical decompression of the median nerve. This consists of sectioning the deep transverse carpal ligament in the hand. When this surgical procedure is done, special attention should be made so that the recurrent branch of the median nerve to the thenar muscles is not damaged. It comes off from the median nerve at the distal radial edge of the transverse carpal ligament.

Discussion

The most reliable clinical findings in carpal tunnel syndrome in the order of their importance are:

(1) all objective sensory findings are limited to the distribution of the median nerve, distal to the wrist. However, some patients may complain of a referred type pain in the forearm and on occasion as proximal as the shoulder. A Tinel's sign and a wrist flexion test and sustained grip test are frequently positive. Thenar atrophy is present only in a small percentage of the cases, but can be rather marked in those cases which have been present for some time. The tourniquet test is helpful in establishing the diagnosis. The EMG test is a special test which requires special machinery and someone to operate it. However, this information is very helpful. This is a clinical syndrome and the EMG can be normal and the patient have rather obvious clinical findings.

The carpal tunnel syndrome is more common in females than in males. In the approximate relationship, 70 per cent of the cases are females and 30 per cent are males.

Trauma to the wrist and hand does play a part in some cases. It can be seen following a Colle's fracture. It can also be seen following a fracture or dislocation of the carpal bones or just a direct blow to the hand or wrist.

Most people sleep with their wrist in slight flexion. This flexion of the wrist can precipitate the paresthesias which awaken the patient at night. As I previously mentioned, a splint to hold the wrist in neutral position at night is often quite helpful.

On further examination there can be an associated tenosynovitis of the trigger finger or de Quervain's disease type. Carpal tunnel has been frequently associated with rheumatoid arthritis. Other conditions for which it has been found to be associated with are peri arthritis of the shoulder, Dupuytren's contracture, Lupus erythematosus, multiple myeloma, calcific tendinitis at the wrist, psoriasis, myxedema, alcoholic neuropathy, gout and Raynaud's syndrome. However, most cases have no associated disease or injury.

It is my routine to treat most cases conservatively as previously outlined for approximately one month. If the symptoms are persistent then I feel that surgical release of the transverse carpal ligament and freeing of the median nerve in the carpal tunnel should be done.

Summary

The carpal tunnel syndrome should be considered particularly in the middle-aged housewife who complains of numbness and tingling in the index, long and ring fingers and the thumb, which is worse at night and after excess use of the hands. Pain may be referred to the forearm and as high as the

shoulder. Tinel's sign and wrist flexion test are usually positive. The treatment consists of splinting, injection of steroids and section of the transverse carpal ligament.

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ACADEMY OF DERMATOLOGY TO HOLD SCIENTIFIC MEETING IN MIAMI

The American Academy of Dermatology (AAD) will hold its 28th Annual Meeting Dec. 6-11, 1969 in Bal Harbour, Fla. All scientific sessions and postgraduate courses will be held at the American Hotel.

The AAD meeting will include two full days (Saturday and Sunday, Dec. 6 and 7) of postgraduate courses in clinical dermatology and cutaneous biology. On Monday through Thursday (Dec. 8-11) research and clinical investigators will give scientific papers on their studies of the causes, diagnoses and treatments of skin diseases. Special features include an all-day symposium on gross and microscopic dermatology, during which some 100 dermatologists will give short reports on rare and unusual cases; a Residents' Forum for presentation of research papers by dermatologists-

in-training, and a series of breakfast and luncheon conferences and seminars on specific problems.

The annual meeting is expected to attract dermatologists from the United States and several other countries. The Academy, which now has over 3,000 members, was founded in 1938 to further the continuing educational interests of dermatologists in clinical practice and to foster the scientific study of skin diseases.

Current officers are: President, Walter C. Lobitz, Jr., M.D., Portland, Ore.; Vice President, Victor H. Witten, M.D., Miami, Fla.; Secretary-Treasurer, Frederick A. J. Kingery, M.D., Portland, Ore.; Assistant Secretary, John M. Shaw, M.D., Tacoma, Wash. and Historian, Samuel J. Zakon, M.D., Chicago, Ill.

MEDICAID MANUAL FOR PHYSICIANS

A Medicaid manual for physicians, compiled and published by the Georgia Department of Public Health, is being mailed to the more than 3,500 physicians participating in the Georgia Medical Assistance Program.

"The advantage to be gained from the manual is that it will provide the physician with a fingertip reference to answer questions which may arise in his Medicaid practice," explained Dixon A. Lackey, Jr., M.D., director of the branch of Medical Assistance.

"As such, the manual should be a timesaver both for the physician and his staff and for the Department in processing his claims. We have tried to make it understandable in lay terms so that the reference can be used by all related personnel."

The manual is arranged into 23 separately numbered sections, grouped under four major areas: general information about Georgia's Medicaid program, coverage of physicians' services, reasonable charge and claims procedures, and a summary of responsibilities of the physician.

The format includes more than 170 medical care topics and definitions cross-indexed for quick reference. There is also an appendix of sample forms used in the program and a drug list index, revised as of July 1, 1969.

The pages have been punched for a three-ring binder to accommodate future revisions in policy and procedures, which will be reported in printed form to correspond with the original sequence of the manual.

Good to superior results were noted in the majority of patients treated with this new steroid impregnated tape.

Experiences With the Use of Flurandrenolone Tape* in Dermatology

HERBERT S. ALDEN, M.D. and PAUL C. CRONCE, M.D., *Atlanta*

ONE HESITATES TO USE SUCH A HACKNEYED WORD as "new" to describe any technical procedure in medicine, but there *is* a fresh development in the form of a corticosteroid impregnated plastic tape for certain skin affections, which seems to merit attention.

The use of plastic film as a protective and occlusive dressing in dermatology has been shown to be adequate in the care of some skin diseases when used with the corticosteroid creams. For some time many dermatologists have been using such creams under an application of Blenderm® Surgical Tape, a transparent, semi-pervious plastic, which contains a less irritating adhesive than does ordinary surgical tape. It seems logical and practical therefore to combine the corticosteroid with the adhering agent, thus utilizing the good qualities of both. This has been done in "Cordran® Tape," a combination of Flurandrenolone (Lilly) and Blenderm® Surgical Tape. It contains 4 micrograms of Flurandrenolone per square centimeter, comes with a paper liner, and is packaged in a width of 7.5 centimeters.

To test the advantages and disadvantages of this new method of application of Flurandrenolone to the skin, Cordran® Tape has been studied in a wide variety of skin eruptions in various locations, and for different periods of time.

In general it can be said that this is a useful modality in many dermatoses, but there are limitations to its use in some areas of the body and some awkwardness in its applications to moving surfaces such as elbows and knees.

Skin Diseases

Most skin diseases are made up of localized "spots" of eruption such as papules, coin-sized macules, small tumors, and variously grouped aggre-

gates of these. No matter whether the disease process is inflammation or hyperplasia, most eruptions affect the skin initially as small and separate foci, and are the reaction of the dermal tissues to some form of injury. These "spots" of eruption, occurring as insect bites, psoriasis, neurodermatitis or lichen planus, to name but a few, result in itching or other discomfort; then scratching furthers the mischief and the cycle of eruption is repeated. If protection from further injury and relief of itching can be had early in the cycle and can be pursued with sensible vigor, the natural recuperative powers of the dermal epithelium will result in the disappearance of the eruption. It is in these small areas of eruption that Cordran® Tape finds its best field of usefulness. For good results, it must be applied with judgment, perspicacity, and good timing, and thus cannot be considered as a dermal medication for general or indiscriminate use.

In this study, Cordran® Tape was used in 100 selected patients. Its application was carefully explained to each patient, with special attention to the following instructions as given in the literature accompanying each roll of tape:

"If shower or tub baths are to be taken, they should be completed before Cordran Tape is applied. Gently clean the area to be covered to remove scales, crusts, exudates, and any previously used ointments or creams. A germicidal cleanser should be used to prevent the development of odor under the tape. . . . The skin should be dry before the tape is applied."

"Cut the tape to the desired length; do not attempt to tear it. The tape should be long enough to cover a quarter-inch margin of normal skin. To separate pieces of tape from the paper liner, use either of the following methods:

(a) Pinch back an "ear" not more than $\frac{1}{16}$ inch wide at a corner.

* Cordran® Tape (Lilly).

(b) Make a small tear $\frac{1}{8}$ inch long into the edge near a corner.

Carefully peel the liner from the adhesive surface of the tape to prevent the tape from sticking to itself. If a long piece of tape is to be used, peel the liner from the first two inches of it, attach the uncovered portion to the skin, and then peel the remainder of the liner at the same time that the tape is applied to the skin. The skin should be under gentle tension as the tape is affixed. After it has been applied, stroke the back of the tape, especially the edges, with moderate pressure to produce tight adhesion. Practice may be required to develop skill in application." (Figure # 1)

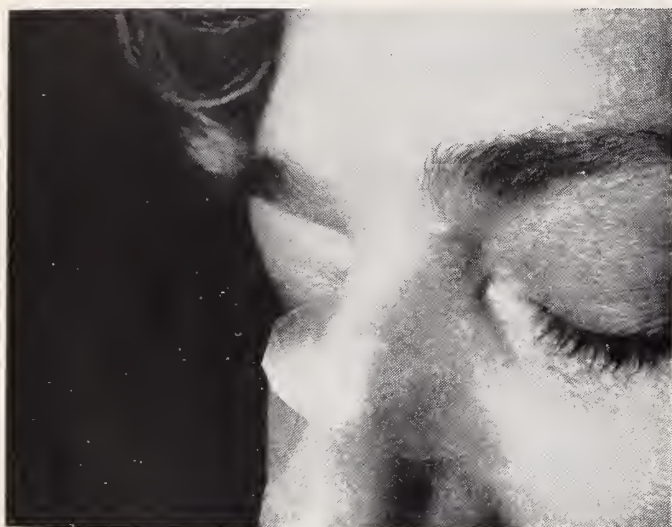


FIGURE 1
Application of tape.

In most cases the tape can remain for 24 to 48 hours or it can be used only during the night. If no "dampening," miliaria, or irritation occurs, the tape can be used for many days.

Summary of Cases

The 100 cases in which it was used may be summarized as follows:

The application of Cordan® Tape was considered as superior therapy in 35 per cent; good in 28 per cent; fair in 26 per cent; and poor in 11 per cent. It appeared to be particularly advantageous in nummular psoriasis, but poorly tolerated when applied on large psoriatic patches. Good patient acceptance and improvement were noted when the tape was used as a daytime application to palmar psoriasis, but the results in pustular psoriasis of the sole were relatively poor. In discoid lupus erythematosus of the face, it was superior therapy and had the added advantage of being easily covered with cosmetics (Figure # 2). These benefits were also evident in small areas of neurodermatitis, chronic



FIGURE 2A
Discoid lupus erythematosus.

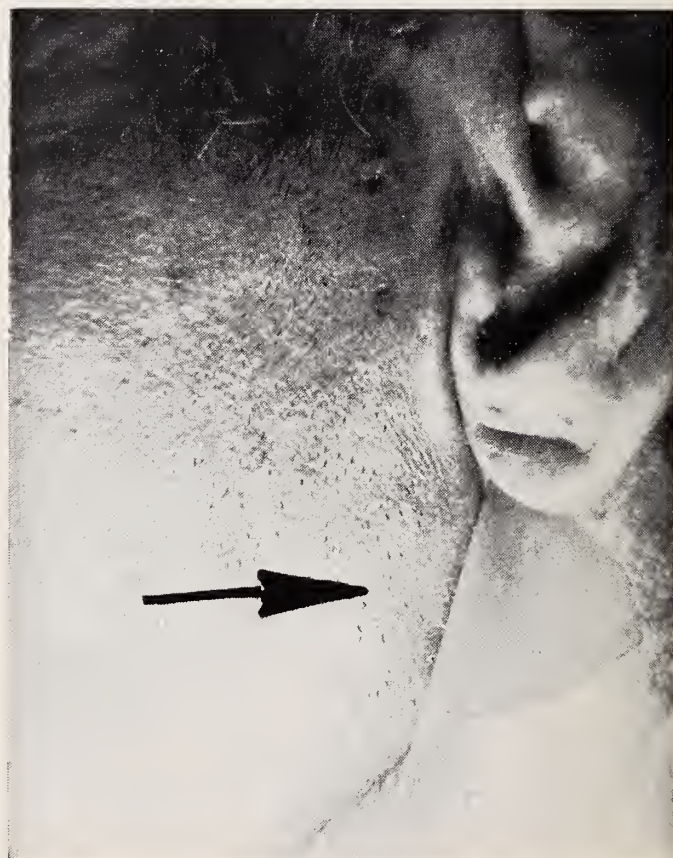


FIGURE 2B
Discoid lupus erythematosus two months after use of Cordan® Tape.

nummular eczema, and lichen planus on ankles and wrists. However, the opposite was true when the treatment was used with the acute vesicular

eruptions. Acute eczematoid dermatitis and contact eruptions were worsened by its application in eight out of eleven patients. Of course, in none of these conditions could the tape be considered curative, since additional forms of therapy must be used, but, except for acute eruptions, it was considered comforting and acceptable.



FIGURE 3

Application of Cordan® Tape following minor surgery.

When Cordan® Tape was used as a postoperative dressing it was considered to be superior (Figure # 3). Such usage included protective dressing after removal of plantar warts, in the erythemas following surgery and small hypertrophic scars on the nose or cheeks, or small areas of radiodermatitis. Since the tape will adhere to the lips (Figure # 4) and glans penis it is a superior protective dressing in these areas. Of eight patients with painful scars and small keloids there were none who did not receive some relief and comfort. This was true also in corns and calluses of the toes and feet.

Of the three patients with granuloma annulare in which the tape was used consistently for six to eight weeks, all received lasting benefit and the tape was considered curative in this skin disease.



FIGURE 4

Postoperative scar of lip.

Summary

A plastic tape containing flurandrenolone was used as a protective therapeutic dressing in 100 consecutive patients with various skin diseases. The treatment was found to be superior or good in 63 per cent if used on small areas of eruption in chronic or subacute disease, especially psoriasis, neurodermatitis, and discoid lupus erythematosus.

Although significant irritation occurred when the tape was used on large areas, in areas where sweating and "dampening" might occur and during hot weather, this was less than might be noted from the use of other types of occlusive adhesive dressings. The tape was a superior dressing for small postoperative wounds, scars and callus, and in general met with good patient acceptance in spite of occasional difficulties in its application.

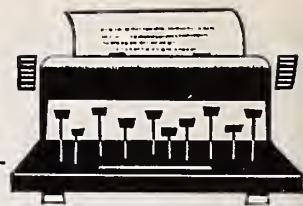
Flurandrenolone Tape was furnished as Cordan® Tape by Dr. Linn Jones, Medical Research Division, Eli Lilly Research Laboratories, Indianapolis.

1293 Peachtree St., N.E.

Most medical students are attracted to surgery. Its positive results please them. The bloody drama of the operation fascinates them, the dramatic force of some great operator stirs their admiration. They note decisive achievements and wonderful successes. They hear little of failures. They know nothing of the haunting anxieties, the keen disappointments, the baffling perplexities, the dread responsibilities, and the numerous self-reproaches of one who spends his life as an operating surgeon.

Yet few even of these admiring students become surgeons. Some suffer disenchantment during their student days. Many lack the necessary qualities. Many shrink from the responsibility. Some never get an opportunity. Many find an opening in general practice and seize it for a livelihood. The very best minds in the class seldom lean to surgery. This is a sad admission, but it is true. Men with deep, broad, philosophic minds usually tend to laboratory science and experimental medicine. That such minds are apt to be repelled by surgery is often the fault of the teacher.

—J. Chalmers da Costa



New Physician—Lawyer Code Adopted

OF THE THREE TRADITIONAL LEARNED PROFESSIONS, medicine, law and the ministry, there has developed over the past several years a greater propensity for misunderstanding and frequently irritating controversy between medicine and law than would seem likely.

Oddly enough, such controversy as from time to time develops is as frequently related to the similarities between the two professions as it is to their differences. As professionals the ingredient common to both is time—or rather the lack of it—as both practitioners must respond to the needs of patient and client.

In 1957 a joint venture of the Georgia Bar Association and MAG produced a code of interprofessional cooperation that appeared useful at the time. If it failed ultimately to prevent controversy, then at least it served well as a guide “of sorts.” But like many such agreements, frequent updating is essential.

A new code has recently been adopted by the MAG Council and the Board of Governors of the State Bar of Georgia, and will be available for general distribution to the membership of both professions in the immediate future.

The new code, “Principles Governing Physician-Lawyer Relationships,” is virtually a verbatim copy of a document adopted earlier by the Atlanta Bar Association and the Fulton County Medical Society. It is strongly recommended that a copy be retained in your desk drawer for quick reference as needed.

The essence of the new code is its attempt to conserve the time of both the physician and the lawyer in their professional relations with each other. New and exact rules related to such matters as the taking of depositions, advance notice of subpoenas, pre-trial conferences and the like are spelled out with greater clarity than is now the case.

Hopefully, at least, a modicum of uniformity will replace the hodge-podge, crazy-quilt uncertainty now attending many professional exchanges between physicians and attorneys.



WHO IS THE AMA?

RONALD F. GALLOWAY, M.D.,* *Augusta*

MANY OF US AS BUSY PRACTICING PHYSICIANS look upon our American Medical Association as a handful of men in a Chicago office who make any necessary decisions concerning the general rules by which we practice medicine in this country. This is far from true. It seems worthwhile, therefore, to briefly discuss just who the AMA really is. In order to do this, one must know what the AMA is and what it does.

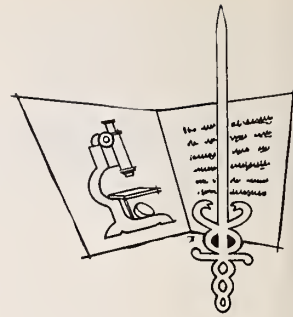
Although the home office of the American Medical Association is in Chicago, there are members of the AMA all over the world. Besides its president, executive vice-president, and board of trustees your AMA staff is divided into divisions of communications, public affairs, law, management services, medical education, scientific activities, scientific publications, health research, tobacco and health, aging, blood, continuing medical education, cutaneous health and cosmetics, exercising and physical and mental impairment, rehabilitation, drugs, environmental and public health, foods and nutrition, health manpower, and legislative activities. It publishes *Medical World News*, *The AMA News*, *Today's Health*, the *JAMA*, and several special scientific journals. That's essentially what the AMA is.

What the AMA does, or, more specifically, how its policy is decided is interesting. Most of its policies originate from one individual physician's thoughts. Each year, many resolutions are adopted by the AMA which began as a single idea of a practicing physician somewhere in America. This idea has been reviewed by a county medical society, a state medical society, a reference committee of the House of Delegates of the AMA, and they by the House of Delegates itself. Then, this idea becomes the policy of the AMA. This policy then, as do most of the policies of the AMA, did not originate in Chicago. Perhaps Atlanta, perhaps Hahira, perhaps San Francisco.

Finally, WHO IS THE AMA? The House of Delegates of the AMA is composed of physician representatives from all over the country. California, for instance, has 24 delegates, Delaware has one, and Georgia has four. These delegates are your representatives. They are either elected or nominated by you and their responsibility is to represent you in the House of Delegates of the AMA. However, you, the practicing physician and member of the AMA is who the AMA really is. Whether or not you exercise this privilege and speak your voice in the AMA through your delegates or directly is up to you. But you do have a voice, and that you should know. Perhaps, in the future when we refer to the AMA in the third person, we will look up to see just who it is we're discussing and will find ourselves looking straight into a mirror. This is as it should be.

1467 Harper Street

* Vice-President, Medical Association of Georgia.



ONE MEDICAL COMMUNITY'S FIGHT AGAINST CANCER . . . "SAVANNAH"

MASON G. ROBERTSON, M.D., F.A.C.P., *Savannah*

THE MEASURE OF STANDARD OF EXCELLENCE IN MEDICAL CARE in any community is often reflected in the management of certain disease problems. Arthritis, stroke rehabilitation, tuberculosis are but a few examples showing how well-organized teams of physicians, nurses, technicians, health officers, and lay volunteer groups, working together, help to combat illnesses which transcend the simple doctor-patient structure of many less complex illnesses.

Cancer is another complex, tragic problem which is a measure of the community's health resources and ability to care for its sick.

Oncology is not really a separate branch of medicine at all. It embraces every other branch of the art of healing from the general practitioner of family physician to the super-specialist. There are malignant diseases, tumors or cancers for each and every organ and body system. Some are common . . . some are rare.

A community, in order to combat cancer effectively, must have all the well-trained specialists working together smoothly as a team. It is not surprising that a special clinic bringing all of these men together for special conference and consultations might be needed. This is the purpose of a Tumor Clinic.

Back in 1940 a group of Savannah physicians saw the need for such a project. Under the leadership of Dr. Robert Oliver, the Georgia Medical Society sponsored a cooperative body known as the Savannah Tumor Clinic. The original clinic was endowed privately, but furnished diagnostic and treatment services to low-income patients through funds from the State Aid Program of the State Health Department, Cancer Control Section. Physicians in the community gave their time voluntarily. The original clinic was housed in the basement of the present Georgia Medical Society building until 1964 when it was moved to the Memorial Medical Center, one of Savannah's major general hospitals.

The year the clinic was moved, the radiotherapy section of the Department of Radiology was expanded and removed from the Diagnostic Section, under its chief, Dr. David E. Tanner, the current radiotherapist, who is also the present director of what is now known as the Savannah Area Cancer Facility. Central to this therapy section was the new Cobalt Teletherapy machine. As the years went by, more and more patients received life-saving as well as palliative treatment from this machine. In 1968 approximately 5,922 radiotherapy treatments were delivered to cancer patients. Plans are underway to install a more sophisticated cobalt machine. Other modalities in the Radiotherapy Department include superficial and orthovoltage x-ray equipment, radioactive isotopes and 200 milligrams of radium. The staff has grown to include two therapy technicians, one registered nurse, one

medical secretary and one nurse's aid . . . in addition to the full time radiotherapist, Dr. Tanner.

Improved Services

During the past year, an important reorganization of the Tumor Clinic has been carried out, designed to improve its services and qualify it for approval of the American College of Surgeons. A Department of Oncology has been formed under the chairmanship of Dr. J. Moultrie Lee, regional liaison officer for the American College of Surgeons and regional medical chairman for the American Cancer Society. On April 17, 1969, the first clinical conference was organized for the benefit of private as well as tumor clinic patients. This conference would permit any physician in private practice to present, without charge, a private patient for expert consultation with various specialists. In addition, the case history of each patient seen in the Tumor Clinic would be periodically reviewed. Each Monday morning since April 21, 20 to 28 physicians have met and discussed plans of therapy for individual patients. At the close of each conference a film, sponsored by the American Cancer Society Professional Education Committee, is shown concerning recent developments in the diagnosis and treatment of specific cancer problems.

Finally, the Tumor Clinic has set up a Tumor Registry, sponsored cooperatively by the American College of Surgeons, the Georgia Regional Medical Program and the American Cancer Society. The purpose of this registry is to help pinpoint what types of cancer are more common in this area and which are more rare, and to reveal how well the local program is doing in early detection and long-term survival of patients being followed in the clinic when compared to other such cancer centers throughout the country.

At present, 850 active cases of cancer are being followed in the Tumor Clinic. In addition, 450 patients with benign non-malignant tumors are being followed. On each visit to the clinic a patient is seen by one of a score or more physicians in the community who is volunteering his services each week. Over the years many of Savannah's distinguished physicians and surgeons have served in a similar capacity.

The Tumor Clinic, Department of Oncology, Radiotherapy Section and Tumor Registry, although officially funded and operated by different agencies—county, state, and federal, are all coordinated under the direction of the Oncology Board, which is a sort of interlocking directorate of the various participating physicians.

Savannah is proud of the struggle its physicians, nurses and health officials are waging against cancer. Only in a forward progressive community can such a sophisticated, technically advanced program be carried out with this degree of success.

600 E. 70th Street

There is a tremendous literature on cancer, but what we know for sure about it can be printed on a calling card.

—August Bier (1861-1949)



CORONARY HEART DISEASE AND SMOKING

A Reducible Risk Factor

CURTIS G. HAMES, M.D., *Claxton*

AMONG THE WELL-KNOWN RISK FACTORS associated with the development of coronary heart disease, cigarette smoking is one of the most prevalent. On the other hand, cessation of cigarette smoking has been proven to be the most effective method for reducing the risk of two major diseases, lung cancer and coronary heart disease. In fact, breaking the habit of inhaling smoke is, so far, the only preventive medical advice associated with a prominent reduction in myocardial infarction and sudden death. This was first shown in the Framingham and Albany heart studies where the risk of coronary heart disease or death for ex-cigarette smokers was nearly equal to the risk for those who had never smoked. From the Tecumseh Study in Michigan it was reported that among male ex-smokers, no cases of coronary heart disease were diagnosed below age 50.

The Health Insurance Plan Study in New York revealed that men who stopped smoking cigarettes within the preceding five years have about the same risk of sustaining a myocardial infarction as men who have never smoked. Several retrospective studies around the world and the Canadian Report on Smoking and Health likewise have unequivocally and without a single exception concluded that the excess risk associated with cigarette smoking is rapidly eliminated when men quit smoking. The Report of the Advisory Committee to the Surgeon General stated: "Any etiologic role of smoking in myocardial infarction should relate more to acute occlusive mechanisms than to the development of chronic arterial disease."

At the present, the Evans County Epidemiological Study in Georgia is completing the second round of examinations on over 2,500 persons. This examination includes a detailed smoking questionnaire. Preliminary analysis shows the cigarette smoker to have an excess risk of myocardial infarction. Interestingly, the lower coronary heart disease rate among the black race can perhaps be partially explained by the differences in smoking habits between the white and black races. White males smoke proportionately more cigarettes than black males—for example, 15 per cent of whites and only 8 per cent of the blacks smoked more than 20 cigarettes per day. As found in previous studies, pipe and cigar smokers in Evans County appear to have essentially the same low risk as the non-smokers.

Thus, there is overwhelming epidemiological evidence to support the advisability of refraining from smoking cigarettes if one wants to reduce his risk for the development of coronary heart disease.

2 North Newton Street



“FINAL WORD ON PROFESSIONAL ASSOCIATIONS”

JOHN L. MOORE, JR., *Atlanta**

ON AUGUST 8, 1969, THE INTERNAL REVENUE SERVICE issued Technical Information Release No. 1019 finally conceding its total surrender on the taxability of professional associations as corporations. The March, 1969, issue of this Legal Page reviewed the history of the long battle between the Internal Revenue Service and professional groups over their taxability. Briefly, the Internal Revenue Service first sought to make it impossible for professional groups to meet certain earlier regulations of the Service taxing partnerships as corporations. After the enactment in most States of legislation allowing the formation of “professional associations,” the Internal Revenue Service adopted new regulations seeking to make it impossible for professional associations to be treated as “associations” under the taxing statutes and regulations.

Subsequently, many of the United States District Courts and most of the Federal Circuit Courts had found against the Internal Revenue Service and for the taxpayers. In no case has the Internal Revenue Service won the decision.

However, the Internal Revenue Service had continued to fight every case as far as it could. The important Release of August 8, 1969, simply means that the Internal Revenue Service will no longer contest the basic taxability as a corporation of a professional association, provided the professional association is organized along the lines of the groups which have won the cases. This means that, with some careful legal work, it is almost certain that the basic question is now settled if the professional association is properly organized.

Tax Comparison

The principal advantage of the formation of a professional association is the ability to adopt a more flexible profit sharing or pension plan. Individuals or partnerships may adopt HR-10 plans but the maximum deduction for an individual or a partner is \$2,500 a year. Under a corporate plan, as much as 15 per cent of the compensation otherwise payable to the physician may be set aside in a profit sharing or pension plan each year and not taxed to the professional man until he retires. In addition, certain insurance fringe benefits may be enjoyed by stockholder-employees or professional associations taxed as corporations which are not available to individuals or partners of a partnership.

Now that the Internal Revenue Service has conceded the point, it makes sense for any group of physicians to discuss the formation of a professional association. It should be remembered that under Georgia law there must be at least two persons practicing the same profession to organize a professional association.

*Suite 1220
C & S Bank Building*

* Prepared at the request of The Medical Association of Georgia. Mr. Moore is a member of the firm of Alston, Miller & Gaines, general counsel to The Medical Association of Georgia.

THE ASSOCIATION



NEW MEMBERS

Carlock, Keller S., M.D. Active—Fulton—PD	3162 Piedmont Rd., N.E. Atlanta, Georgia 30305
Carrington, Louie H., M.D. Active—Fulton—PD	6565 Riverside Dr., N.W. Atlanta, Georgia 30328
Cooney, James P., M.D. Service—Fulton	938 Peachtree Street, N.E. Atlanta, Georgia 30309
Davis, Dave M., M.D. Active—Fulton—P	1999 Cliff Valley Way, N.E. Atlanta, Georgia 30329
Goodwin, Burton D., Jr., M.D. Active—Ga. Medical—R	Memorial Hospital Savannah, Georgia 31401
Higgins, Alexis C., M.D. Active—Meriwether- Harris—PM	The Foundation Warm Springs, Georgia 31830
Kerman, Edward F., M.D. Active—Fulton—P	127 Peachtree Street, N.E. Atlanta, Georgia 30303
Kim, Jong-In, M.D. Active—Fulton—ANES	2760 Felton Drive East Point, Georgia 30344
Lanier, Bob G., M.D. Active—Fulton—I	33 Baker St., N.E. Atlanta, Georgia 30303
Lathan, Samuel R., M.D. Active—Fulton—I	46 Fifth Street, N.E. Atlanta, Georgia 30308
Lindsey, I. Lehman, Jr., M.D. Active—Fulton—N	1365 Clifton Rd., N.E. Atlanta, Georgia 30322
Lorenz, Max P., M.D. Active—Cobb—U	823 Campbell Hill Street Marietta, Georgia 30062
Lucas, George W., M.D. Active—Fulton—SU	490 Peachtree Street, N.E. Atlanta, Georgia 30308
Pou, Leo H., Jr., M.D. Active—Fulton—ANES	2760 Felton Dr. East Point, Georgia 30344
Rayel, Peter A., M.D. Active—Fulton—I	6363 Roswell Rd., N.E. Atlanta, Georgia 30326
Ricks, Robert L., M.D. Active—Fulton—OBG	565 Fair St., S.W. Atlanta, Georgia 30314
Rivkin, Laurence M., M.D. Active—Fulton—TS	490 Peachtree Street, N.E. Atlanta, Georgia 30308
Walton, Kenneth N., M.D. Active—Fulton—U	1365 Clifton Rd., N.E. Atlanta, Georgia 30322
Warren, Thomas L., M.D. Active—Fulton—OBG	340 Boulevard, N.E. Atlanta, Georgia 30312
West, John H., M.D. DE-2—Fulton—I	80 Butler St., S.E. Atlanta, Georgia 30303

PERSONALS

Third District

Jose C. Serrato, Jr., was designated as a member of the American delegation to the International Society of Orthopedic Surgery and Traumatology International Congress in Mexico City, October 6-10, 1969.

Agatha Thrash helped conduct a television series on smoking and health, aired over Columbus's Channel 9, in August.

Fourth District

Robert M. Fine was elected president of the Georgia Society of Dermatologists at their last meeting held in Savannah in May.

Fifth District

William S. Hagler spoke on "Experiences on the Good Ship Hope," at the September meeting of the DeKalb County Medical Society.

Seventh District

Allen Macris lectured on "Smoking and Lung Cancer" during a "Stop Smoking" campaign sponsored by the Cobb County Medical Society in August.

William Tryon of Marietta organized a five-night program "designed to get Cobb Countians off the smoking habit" in August. Dr. Tryon said the idea was "to provide those who want to quit smoking with enforcement through diet, exercise and psychological help." **Ronaldo Barrios** lectured on "The Will and the Quitting," during the program.

Tenth District

D. Frank Mullins, Jr., and **W. B. Mullins** announce the association of **James L. O'Quinn** in the practice of Pathology and Laboratory Medicine. Dr. O'Quinn was graduated from the Medical College of Georgia in 1960. He began specialty training in Pathology at Eugene Talmadge Memorial Hospital and subsequently served two years as pathologist at the U. S. Army Hospital, Fort Chaffee, Ark. Residency training in Pathology was continued for four years at Johns Hopkins Hospital, Baltimore, Md., one year at Memorial Hospital for Cancer in New York City, and one year at Memorial Hospital of Hollywood, Fla. He is a Diplomate of the American Board of Pathology. Dr. O'Quinn resides with his wife, the former Judith Ayers of Martinez, and children: James, Jr., Kelly and Bart, at 205 Chatham Road, Augusta.

M. A. Hubert retired September 30 after more than 40 years of active practice. He plans to continue as physician to the University of Georgia Athletic Club.

DEATHS

James J. Clark

James J. Clark, retired radiologist, died August 15 at Emory University Hospital. He was 80.

Dr. Clark had retired as associate professor of surgery in the department of radiology of Emory University and as radiologist of Emory University Hospital. He also served as radiologist for Henrietta Egleston Memorial Hospital for 35 years.

He served as consulting radiologist at Georgia Baptist Hospital, Grady Hospital, and the Good Samaritan Clinic. Dr. Clark retired in 1963 after 50 years of practice.

Since his retirement, he had been a member of the Honorary Staff, Egleston Memorial Hospital and Emory University Hospital. Dr. Clark was an emeritus member of the Radiological Society of North America, a fellowship emeritus in the American College of Radiology, a life member of the Fulton County Medical Society and the Medical Association of Georgia. He was a Diplomate of the American Board of Radiology and a founding member of the Georgia Radiological Society, serving as president of that society in 1938 and 1939.

Dr. Clark served on the Mexican border in 1916 with the New York National Guard and then served in the Medical Corps of the U. S. Army in World War I. When the war ended, he was chief of the radiological department of the general hospital at Fort McPherson.

Born in New York City, he was graduated from the University of Buffalo in 1911. He interned at Erie County Hospital in Buffalo and St. Mary's Hospital in Rochester. He then joined his father in medical practice in 1913 in Olean, N. Y.

Dr. Clark is survived by a daughter and a sister.

L. G. Neal

L. G. Neal, Sr. died August 1 at his home in Cleveland, following an extended illness.

Dr. Neal was graduated from Emory University in 1916, as president of the first class to be graduated from that School of Medicine. He began his practice in Cleveland in 1919 after a tour in Europe as a captain in the Army Medical Corps during World War I. Until his retirement in 1967 he was active in medical and civic affairs: he was a member of the Academy of

General Practice, served for eight years as a member of the State Board of Medical Examiners, and was an active member of the Ninth District Medical Association.

He was a member of the Yonah Lodge No. 382, F. & A.M., serving as Worshipful Master 11 times over a period of almost 50 years, and also was a member of the Yaarab Temple of the Shriners in Atlanta.

Dr. Neal was also a past president of the Cleveland Kiwanis Club, of which he was a charter member. He also served as a commander of the Roy Head Post of the American Legion.

Until his illness, he was teacher of a Sunday School Class at Cleveland United Methodist Church, where he also served on the board of stewards.

He is survived by his widow, Mrs. Pauline Butt Neal of Cleveland; one son, Dr. L. G. Neal, Jr., Cleveland; one daughter, Mrs. Earl Payne, Cleveland; his mother, Mrs. Floy Neal, Atlanta; three brothers and a grandson.

Stacy Hammond Story, Jr.

Stacy Hammond (Pete) Story, Jr., died August 19 in Valdosta after a long illness. Dr. Story was 44 years old.

A native of Greensboro, N. C., Dr. Story was graduated from Emory University and the Emory Medical College. He interned and did his residency work in internal medicine at the South Carolina Medical Center at Charleston. Prior to moving to Valdosta he had served two years as a Navy physician.

He was a fellow of the American College of Physicians, had served as chief of staff of Pineview General Hospital in Valdosta and was a past president of both the South Georgia and Eighth District Medical Societies.

Dr. Story was a member of the board and a past president of the Valdosta Country Club, was on the board of the United Fund and the Boys' Club and was a deacon of the Westminster Presbyterian Church of Valdosta.

He is survived by his widow, the former Eleanor Calley of Huntington, W. Va.; three sons: S. H. (Chip) Story III, Stephen Story and Michael Story; a daughter, Ellen Brent Story, all of Valdosta; his mother, Mrs. S. H. Story of St. Simons Island, and a sister, Mrs. William Hungerford of St. Simons.

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63rd Annual Meeting
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November 10-13, 1969

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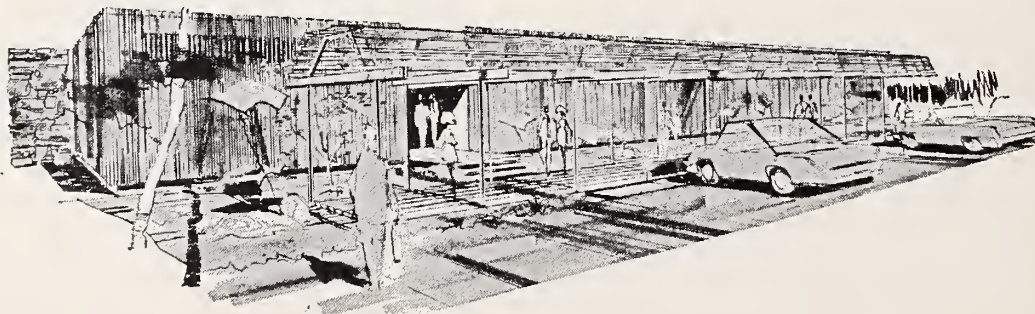
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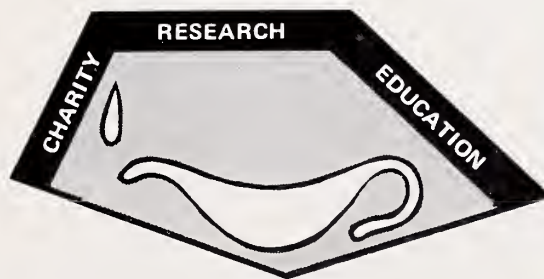
Georgia Hospital Association

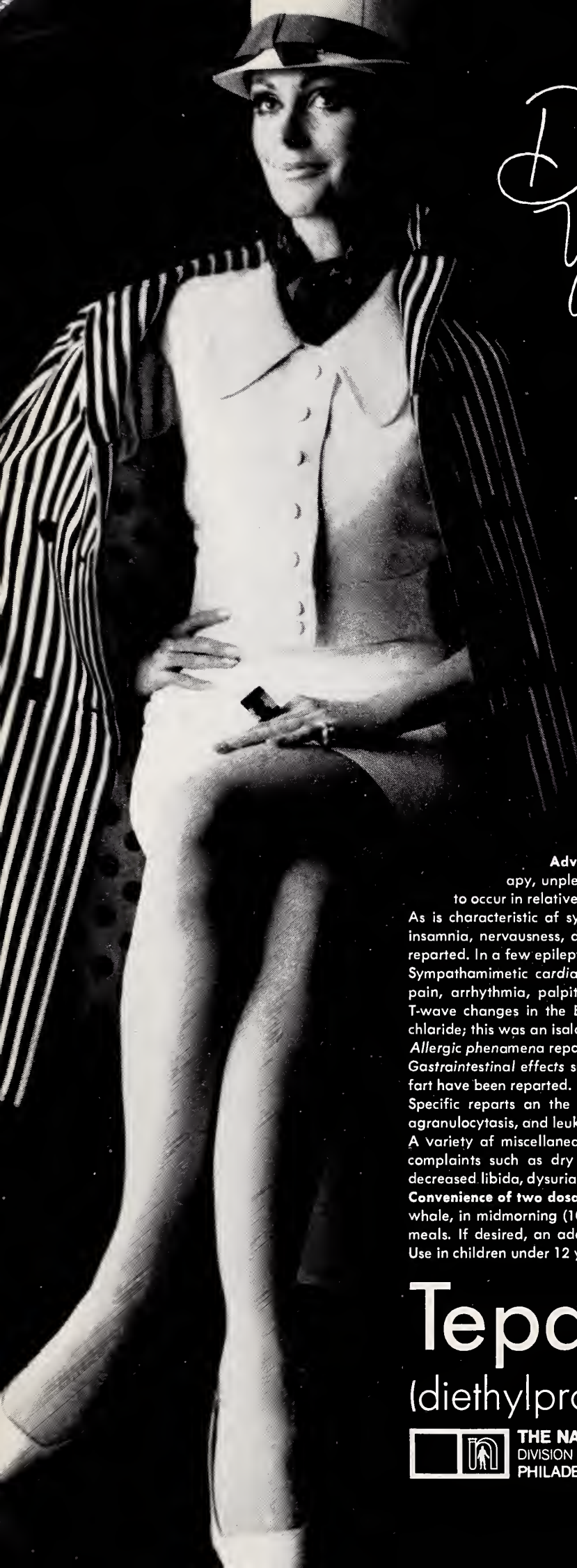
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- (1) Siver, R. H.: CMD, 21:109, September 1954. (2) Frykman, H. H.: Minn. Med., 38:19-27, January 1955. (3) McGivney, J.: Tex. State Jour. Med., 51:16-18, January 1955. (4) Quehl, T. M.: Jour. of Florida Acad. Gen. Prac., 15:15-16, October 1965. (5) Weekes, D. J.: N.Y. State Jour. Med., 58:2672-2673, August 1958. (6) Weekes, D. J.: EENT Digest, 25:47-59, December 1963. (7) Abbott, P. L.: Jour. Oral Surg., Anes., & Hosp. Dental Serv., 310-312, July 1961. (8) Rapoport, L. and Levine, W. I.: Oral Surg., Oral Med. & Oral Path., 20:591-593, November 1965.

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Designed by Marie Seaman.

Special Article

Efficiency in Medical Practice

KRIKOR SOGHIKIAN, M.D., Oakland, California

THE WORD "EFFICIENCY" sounds somewhat alien to the field of medicine. It reminds us of business and industry, of automation, of profits and losses. As such, it seems unacceptable in our traditional view of medical care as strictly an interpersonal relationship. But there is ample reason for us to consider efficiency within the context of medical practice. Recent advances in medicine have created complex, time-consuming activities for physicians. More people are asking for more and better health care. Yet the number of physicians in the United States is not increasing in proportion to the demand, in spite of new medical schools and the advent of graduates of foreign medical schools. We must therefore develop an efficient system of delivering medical services, a system that will assist the physician in every possible way, and free him from paramedical and non-medical activities so that he may have more time to devote to his primary function, which is patient care.

The Kaiser-Permanente Medical Care Program provides an example of systematic approach to medical care. The program is outlined here; its basic principles are discussed as they relate to efficiency, and the Automated Multiphasic Screening Project which it has engendered is described. These remarks are limited to the Kaiser-Permanente Medical Care Program in Northern California, one of five regions in which medical services are provided by similar complexes, the others being Southern California, Oregon-Washington, Hawaii, and, most recently, Ohio.

The Kaiser-Permanente Medical Care Program

The Kaiser-Permanente Medical Care Program is a complex of three independent units (Figure 1)

This paper is based on a presentation forming part of a panel discussion of Efficiency in Medical Practice, 114th Annual Session of the Medical Association of Georgia, Augusta, Georgia, May 5-7, 1968.

Dr. Soghikian is Chief of the Division of Preventive Medicine and Health Center, The Permanente Medical Group, Kaiser Foundation Hospital, Oakland, California.

and one "service" unit. Each unit has a specific sphere of activities, but all are geared to a common goal: the provision of comprehensive health care.

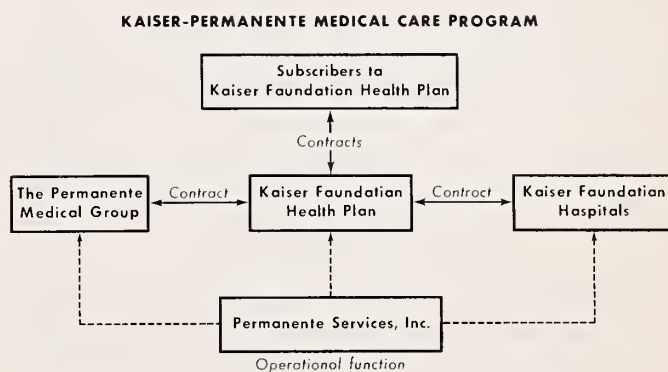


FIGURE 1

Organizational interrelationships of the Kaiser Foundation Medical Care Program in Northern California.

The Kaiser Foundation Health Plan, Inc. is a non-profit organization acting as a third-party carrier. It is governed by a board of trustees, a minority of whom are physicians. It offers tailored programs of medical services to individuals and groups. It arranges with Kaiser Foundation Hospitals, also a non-profit organization, and with The Permanente Medical Group, a partnership of physicians, to provide these services on a contractual basis. The Permanente Medical Group establishes the standards, range, and quality of outpatient and inpatient care. Permanente Services is a subsidiary corporation providing services to the other three units.

The Medical Care Program rests on certain basic principles which have evolved over the years, and which are responsible for its successful growth in all regions. These principles are: group practice, prepayment, integrated facilities, new economics of medicine, voluntary enrollment.

Group Practice

The Permanente Medical Group of Northern California is a multispecialty group of nearly 900 physicians, directed by an executive committee of nine physician members, six of whom are elected for long terms, and three for short terms. Physicians first join the group on a salary basis, and are eligible for partnership at the end of three years; at the present time, approximately 50 per cent of the physicians are partners.

The Group functions in 11 medical centers or "units" in the San Francisco Bay Area. Each center consists of a hospital and an outpatient department located in the hospital building or adjacent to it. Four outlying medical clinics complete the network of facilities. The physician staff in each center is divided into formal departments embracing the usual medical specialties, and is headed by a physician-in-chief (Chief of Staff).

Certain factors inherent in group practice contribute to efficiency. The potency of these factors is attested by the rapid growth of this form of practice in recent years. They relate to the quality of medical care, physician productivity, and benefits for the physician.

Quality of Medical Care

We believe that the best medical care is, in the long run, the most economical. Since the maintenance of a high level of medical care is primarily the responsibility of practicing physicians, their selection assumes major importance.

The physician who applies for membership in our Group is carefully reviewed as to his training, competence, character, and motivation, by his future department head and the physician-in-chief of the local unit. After he enters, his practice is under continuous scrutiny by his associates, who can easily evaluate his clinical judgment and his approach to patient care. A high level of competence is maintained by a well-organized physician education program, by teaching appointments held by many of our physicians in nearby medical schools, and by a variety of research projects in which members are engaged, both at the Kaiser-Permanente centers and at university clinics and laboratories.

Another factor contributing to the quality of care is the ease with which referrals and consultations are available within the Group, insuring that patients receive the highest standard of treatment available. No physician needs to practice beyond his ability for fear of losing a patient to the consultant.

Furthermore, because of its large practice the Group has the financial ability to purchase and make

available to patients the most advanced diagnostic and therapeutic tools.

Physician Productivity

Group practice allows for organization and coordination of medical activities for optimum utilization of physician time. Non-medical activities are delegated to ancillary personnel, either paramedical or administrative, and time-saving technologic methods are adopted.

Physician Benefits

Physician benefits are an integral part of an efficient medical practice. A satisfied physician will provide better care than one who is tired, harassed, or disgruntled. When a physician joins the Group he enters an atmosphere of well-organized medical practice where he can put his learning and experience to immediate use. He does not have to go into debt to equip an office. His environment is in many ways similar to that of an academic center, so that the transition between training and practice is minimally traumatic. The large population he serves affords a rich reservoir of challenge for his specialty interests. He is provided with opportunities for education, teaching, and research. His working hours are regular. Night calls are divided among the members of his department. His fringe benefits include vacation, educational leave, sick leave, group disability insurance, group life insurance, malpractice insurance, and retirement.

Prepayment

The Kaiser Foundation Health Plan prepays The Permanente Medical Group a capitation fee for each insured member. The capitation fees are negotiated on an annual basis, thus assuring a regular income to the Group and forming a basis for sound financial practice. The Health Plan also develops forecasts of membership over periods of five to 10 years, which enable the Group to undertake comprehensive planning to meet expected needs.

Prepayment places the responsibility for organization and provision of medical care where it belongs, on the physician's shoulders. The physician can thus control the scope, quality, efficiency, and economy of services. Prepayment also reduces the economic barrier between the patient and his physician, allowing medical need to dictate provision of care regardless of the individual patient's ability to pay for specific procedures.

Integrated Facilities

Table I lists the many facilities and services available on an inter-unit basis. Through such coordination and integration the benefits of modern medical

TABLE I
INTEGRATED FACILITIES

Within Single Unit
Hospital
Physicians' offices
Laboratory
X-ray department
Paramedical services: physical therapy, social service
Physician education: intern, resident, staff
Patient education program
Between Units
Administration
Business operations
Medicolegal functions
Coordination of physician and patient education
Personnel orientation and training, management seminars
Audiovisual center: closed-circuit TV
School of nursing
Central automated laboratory
Specialized diagnostic equipment: scintillation camera
Specialized procedures: neurosurgical, cardiovascular, renal
Computer center

science and technology can be made accessible to large population groups.

Since the Medical Care Program depends primarily on fixed annual dues from its members, its financial integrity is directly related to their state of health; thus, a healthy, paying member is an asset to the program. Consequently, the provision of preventive medical and health maintenance services assumes paramount significance. In this context, the reduction of the economic barrier between patient and physician comes into play. Unhampered by financial considerations, patients can seek early diagnosis and treatment, thus reducing future disability, morbidity and mortality with the attendant social and financial burden. The structure gives the physician an economic incentive to provide high quality care: keeping his patients in optimum health is an important way of holding costs at minimum.

Each applicant for membership in the Kaiser Foundation Health Plan always has available at least one other health insurance scheme as an alternative. After becoming a member of the plan, each subscriber is allowed, during a certain period of each year, to choose again to stay in the Health Plan or to elect a different insurance carrier. This dual choice provides an opportunity for satisfied members to re-enroll, and for those unhappy with their care to leave the Health Plan before their dissatisfaction interferes with their health care, thus allowing smoother and more efficient operation of the medical care program.

The Automated Multiphasic Screening Program

Automated multiphasic screening provides an example of methods devised by physicians of our group

for enhancing the efficiency of medical practice. Multiphasic health screening, with many modifications and improvements, has been in operation at the Kaiser-Permanente Medical Centers in Oakland and San Francisco since 1951 and presently screens approximately 4,000 persons per month.

Automated multiphasic screening (AMS) is an efficient method of applying multiple tests to large population groups. Such screening is generally performed in relation to routine periodic health evaluation, though it may well play a role in preoperative checkups, hospital admission examinations, community health surveys, and epidemiologic studies. The activity can be conveniently divided into four segments: initiation, laboratory screening, computer processing, and physician review.

I. Initiation Phase. Any person 18 years or older may request a multiphasic health checkup by calling the Oakland or San Francisco facility. In response, he receives through the mail an appointment slip, a brochure of instructions and information about the procedures he will go through, and a questionnaire covering his past history, which he is asked to complete at home and bring when he comes for examination.

II. Laboratory Screening. Figure 2 is a diagram of the Automated Multiphasic Screening laboratory at the Oakland facility. Patients register at the reception desk, at approximately 3-minute intervals. They then proceed from station to station through the various test phases listed below, completing the tests within 2 to 3 hours.

Interval history questionnaire—A questionnaire covering the preceding one year is handed to the patient when he registers, with the request that he complete it at any time within the screening period. It is supplemented by question cards, introduced at a later phase (see below).

Electrocardiogram—Six electrocardiographic leads (AVR, AVL, AVF, V₁, V₃, V₅) are simultaneously recorded by means of a direct optical recording electrocardiograph. The tracing is later read by a cardiologist.

Pulse and blood pressure—With the patient supine, pulse and blood pressure are recorded by an automated instrument.

Anthropometry—Weight is measured on a spring scale. The thickness of the subscapular and triceps skinfolds is measured with a caliper. Twelve vertical and transverse body measurements are performed by means of a special anthropometric device with direct digital output.

Chest roentgenogram—A postero-anterior view of the chest is obtained on 70 mm film and subsequently read by a radiologist.

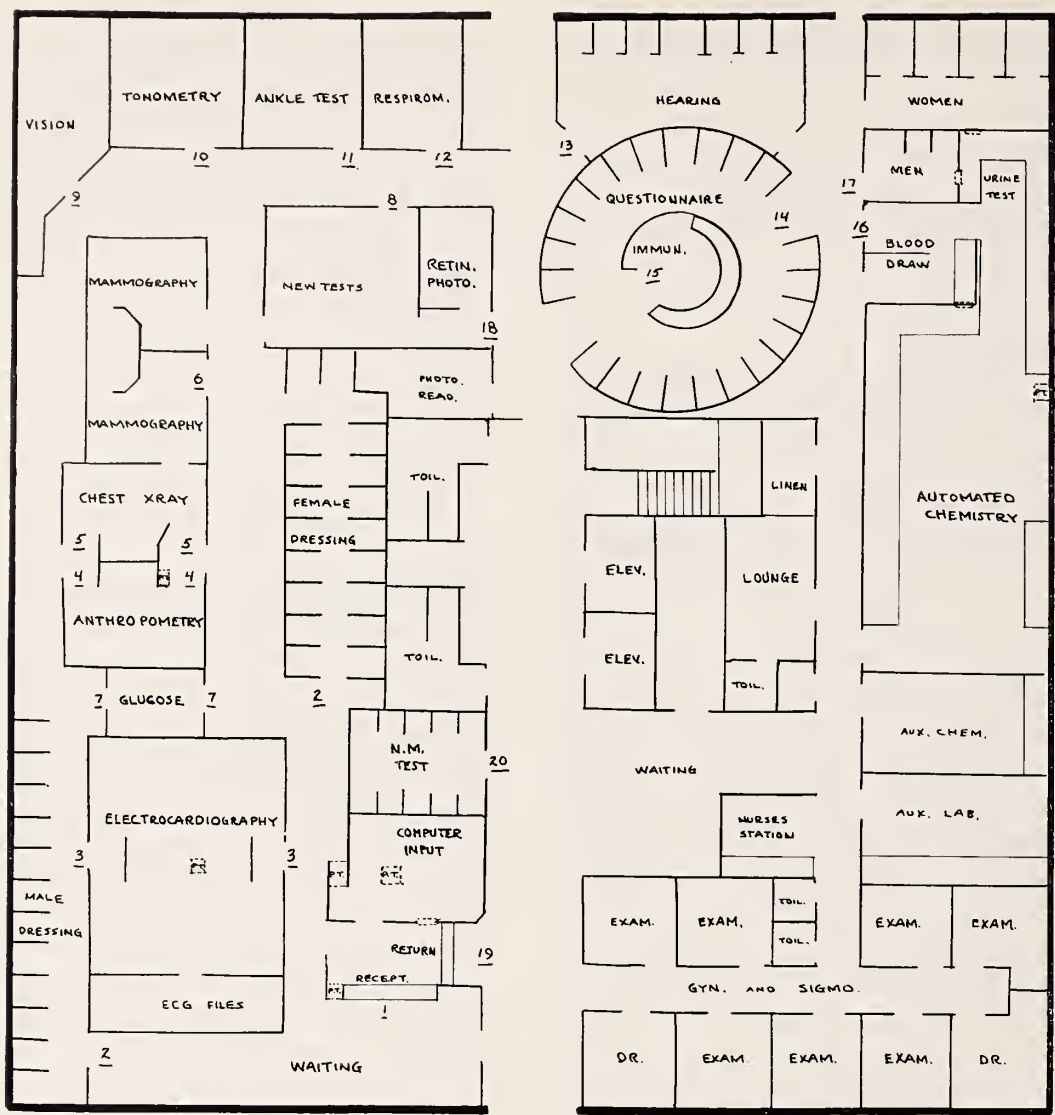


FIGURE 2
Automated Multiphasic Screening laboratory of the Kaiser Foundation Hospital and The Permanente Medical Group, Oakland, California. Reprinted from "The Multitest Laboratory in Health Care of the Future," by Morris F. Collen, M.D., in the May 1, 1967 issue of *Hospitals*.

Mammography—Cephalocaudad and lateral roentgenographic views of each breast are taken in women 48 years or older and are later interpreted by a radiologist.

Glucose ingestion—A glucose load of 75 gm. is administered in 240 ml. of cold, carbonated water dispensed from a vending machine. The time of glucose ingestion is recorded by an automatic time stamp as reference for one- and two-hour serum glucose determinations.

Visual acuity—A standardized wall chart is read.

Pupillary escape test—A light is swung back and forth from one eye to the other, and the eyes are observed for pupillary escape.

Tonometry—Ocular tension is measured by a

tonometer after instillation of a local anesthetic.

Ankle reflex test—The one-half relaxation time of the Achilles tendon reflex is calculated from a paper tracing of the reflex curve, as a screening test for thyroid function.

Pressure tolerance measurement—Sensitivity to pain is estimated by tolerance of increasing levels of pressure applied to the Achilles tendon through an air compressor.

Spirometry—One- and two-second timed vital capacity, total vital capacity, and peak flow are directly measured by a wedge spirometer connected with a digitizer.

Audiometry—Hearing is tested with an automated audiometer for six frequencies in each ear.

Interval medical history cards—A box contain-

ing a deck of 207 prepunched cards, each printed with a single question, is used in lieu of the traditional review of systems. The patient drops each card into either a "Yes" or "No" slot in the box, then reviews his "Yes" answers for confirmation.

Blood analysis—A blood sample is collected one hour after ingestion of the glucose challenge dose. The following tests are performed: hemoglobin and white blood cell count (Coulter counter), serology (venereal disease research laboratories test for syphilis), rheumatoid factor (latex fixation slide test), blood group (micro-agglutination), serum glucose, creatinine, albumin, total protein, cholesterol, uric acid, calcium and glutamic oxalacetic transaminase (multichannel automated chemical analyzer).

Urine analysis—Paper strip tests are used for pH, blood, glucose, and protein; the triphenyl tetrazolium chloride screening test for bacteriuria is read at six hours.

Retinal photography—In patients 48 years or older, and in patients with hypertension or diabetes, a color photograph of the right retina is taken with a fundus camera, and interpreted by an ophthalmologist.

Neuropsychiatric question cards—Patients answer 155 questions as "true" or "false" and drop responses in a box similar to the one used earlier for the interval medical history.

Results Recorded for Computer

III. Computer Processing. The results of all screening tests are recorded for computer input on cards prepunched with each patient's medical record number. Some results, e.g., those of anthropometry, spirometry, and blood chemistry, are punched directly on cards through automated equipment. Others, e.g., electrocardiographic and x-ray interpretations, must be recorded on "mark-sense" cards (cards marked with pencil that can be sensed by a card-reading machine). Demographic data are entered on special "port-a-punch" cards.

The computer receives information regarding the test results through a data communication system. It processes these data for two reports: an immediate or "on-line" report of a specific portion of the data, and a delayed report summarizing the total data.

The immediate report, read before the examined person leaves the premises, comprises results from the following phases:

- Pulse and blood pressure
- Pupillary escape
- Tonometry
- Blood analysis: hemoglobin, white cell count,

and chemistry only (2-hour serum glucose is measured only if an abnormality is reported at this time)

Urinalysis, excluding test for bacteriuria.

On the basis of test validity limits and diagnostic criteria which have been agreed upon previously, the computer is programmed to pinpoint any seriously abnormal result from many of these phases, and to issue in its on-line report "advice rules" which pertain to: 1) Additional tests to be made the same day, or before the patient sees his physician for the review that is part of the multiphasic examination (see IV below), and 2) Follow-up appointment with physician: (a) urgency of appointment, and (b) length of appointment. The physician is thus informed by the computer of any need for immediate action that is uncovered by the multiphasic examination.

The summary report is a statement of all test results, and of all questions answered "yes." It is sent to the patient's individual physician approximately 10 days after the screening examination. Upon receiving the summary report, the physician reviews it, and orders repetition of any procedures that he may deem necessary, or orders performance of related procedures, to be completed and reported to him before the patient visits his office for the Physician Review (below).

IV. Physician Review. The multiphasic examination includes a follow-up office visit with the internist designated by the patient as his personal physician. At this visit, the physician discusses the test results with the patient, and elaborates upon his positive answers to the questionnaire. He then proceeds with a traditional physical examination, and enters his findings and diagnoses on a preprinted form which can be automatically read by an optical scanner for computer input and storage. The physician may, as he considers indicated, order supplementary tests and procedures, and institute appropriate treatment.

Program Criteria

The Automated Multiphasic Program embraces several of the efficiency criteria previously outlined:

Application of the Principles of Preventive Medicine: The entire multiphasic program is based on the concept of early detection of abnormal physiological changes or pathological processes which may be amenable to modification or control.

Utilization of Paramedical Personnel: Except for tonometry and medical questionnaire, which are handled by registered nurses, all of the screening procedures are carried out by trained technicians. A physician supervises the program, but does not have to be present for its day-by-day operation.

Conservation of Physician Time: This is accomplished in two ways: 1) By concentrating his inquiry on the patient's "Yes" answers to the multi-phasic questionnaire, the physician can get information in depth in a shorter period than is possible by other means. 2) By having available a large amount of information about the patient at the first visit, the physician can arrive at an immediate diagnosis or can narrow the diagnostic possibilities, thus saving future appointment time.

Use of Automated Equipment: This obviously allows for rapid and efficient screening, by minimizing personnel involvement in data collection and transmission.

Establishment of a Central Automated Laboratory: Simultaneous analysis of blood samples for multiple constituents reduces cost and makes periodic screening economically practicable.

Electronic Data Processing: The capacity of the

computer for "on-line" data processing, the speed with which it collates data, and its ability to function within a physician-generated frame of reference provide for a range of flexibility and efficiency in medical practice which has only begun to be utilized.

Summary and Conclusions

In order to fulfill the health needs of our nation, the efficiency of medical practice needs to be improved. To accomplish this, some reorientation and reorganization of medical practice is indicated. Efficiency can be achieved in many ways without adversely affecting the quality of medical care. The approach used by the Kaiser-Permanente Medical Care Program is based on specific principles, which have intrinsic validity but may not necessarily be applicable in every given situation. Whenever changes in medical practice are considered, it is vitally important that they be initiated by physicians within the framework of their respective communities.

Kaiser Foundation Hospital

HIGHLIGHTS OF THE MAG EXECUTIVE COMMITTEE OF COUNCIL SEPTEMBER 20, 1969

This summary is being sent to you so that MAG Officers and Councilors may be advised of the actions of the Executive Committee between meetings of Council. It covers only major actions and is not intended as a detailed report in lieu of meeting minutes.

Appointed Carter Smith, Jr., M.D., of Atlanta, Assistant to the Treasurer of MAG.

Noted with regret the pending resignation of J. W. Chambers, M.D., of LaGrange, as Coordinator of the Georgia Regional Medical Program.

Accepted with regret the resignation of William H. Nichols, Jr., M.D., Canton, from the Hospital Activities Committee.

Agreed to request Charles Cowart, M.D., LaGrange, to prepare a policy statement on the use of medical students and paramedical personnel and their relationship to the practice of medicine.

Referred to the Hospital Activities Committee the matter of establishing a liaison committee with the Georgia Nursing Home Association, requesting a report back to Executive Committee.

Received a report from J. Rhodes Haverty, M.D., on sites for the March, 1970, meeting of Council, and voted to recommend to the Council that it meet at the San Joronimo Hilton, San Juan, Puerto Rico. It also

voted to recommend that Councilors who attend equally share the air fare only of the MAG staff.

Received a lengthy report on MAG Executive Staff and an analysis of MAG Operating Policies. Commended the Executive Secretary for these reports and voted to study the reports of action at the October 12 meeting.

Authorized the Executive Secretary to negotiate with the specialty societies for MAG secretarial services at a figure less than \$20 per member.

Heard a progress report on the Headquarters Building with projected completion now scheduled for November 17.

Established priority nominations for appointment to AMA Councils and Committees.

Authorized F. William Dowda, M.D., Atlanta, to seek formation of a separate interprofessional and business group interested in free enterprise.

Heard a report that all actions referred to the Executive Committee by the 1969 House of Delegates have been taken, and commended the Speaker.

Received for information a report on Medicaid, Incorporated.

Voted its next meeting would be held at the Sheraton-Biltmore Hotel, Atlanta, 9:00 a.m., Sunday, October 12, 1969.

*A description of activities in this
important area within the past five years
by the Cobb County Medical Society.*

Medicine and Religion Activities in Cobb County

NOAH D. MEADOWS, JR., M.D., *Marietta*

FIVE YEARS AGO, while president of the Cobb County Medical Society, I was contacted by Dr. Harrison Reeves, who at that time was Chairman of the Committee on Medicine and Religion for the Medical Association of Georgia. He was contacting the local medical societies in Georgia in an effort to establish local committees on Medicine and Religion. We did this in Cobb County and began with programs, usually on a quarterly basis, to which we invited members of the Cobb County Medical Society and the Kennestone Hospital Chaplains Association. The main purpose of the programs was and is to bring members of these two disciplines together for discussion of mutual problems involving total patient care.

In 1966, in addition to the local programs, we decided to have an annual special program, in which we would get a speaker of some national renown or reputation. In 1966, we sponsored the first annual program of this type, and the speaker was Dr. Noel Mailloux, a Dominican Priest and Professor of Psychiatry at the University of Montreal, Canada, who spoke on the program theme, "Law—Criminal, Moral, and Civil." It was during this time that we decided that we would invite the local Bar Association to enter into the programs with us, which they did happily, realizing as we did that there were a number of problems in which all three disciplines of medicine, law, and religion are very closely involved.

In 1967, the annual program speaker was Dr. Alan Watts, President of the School of Comparative Philosophy, San Francisco, California, who spoke on "Eastern and Western Views of Man." We had a very large attendance at this program, approximate-

ly 1,000 people, many of whom came from Atlanta and the surrounding areas.

Symposium on Sexuality

In the spring of 1968, the annual program was a two-day Symposium on "Human Sexuality" and featured the following speakers: Dr. Mary S. Calderone, Executive Director of the Sex Education and Information Council of the United States; Dr. Harold I. Leif, Professor of Psychiatry, University of Pennsylvania School of Medicine; Dr. Seward Hiltner, Professor of the Theology School at Princeton University; and Dr. Ralph Slovenko, Professor of Law at the University of Kansas. This was a very successful program with more than 500 persons attending from as many as 10 other states in addition to Georgia. Some 40 towns in Georgia were represented by participants.

In March, 1969, we sponsored a two-day Symposium again, with the theme being "The Progress of Man Toward the Year 2,000" and featured the following speakers: Dr. William G. Pollard, Executive Director of the Associated Universities of Oak Ridge, Tennessee; Dr. Joseph Fletcher, Episcopal Theology School, Cambridge, Massachusetts; Dr. David M. Hume, Chairman and Professor, Department of Surgery, Medical College of Virginia; Dr. Robert Nenno, Professor of Psychiatry, Rutgers University School of Medicine; and Dr. Max Lerner, widely-known syndicated columnist and Professor of American Civilization and World Politics at Brandeis University. This two-day program was attended by more than 1,000 persons representing Florida, Tennessee, and 25 Georgia towns and cities, with over 140 physicians and wives attending.

These annual symposia, of course, would not have been possible without the support of the pharma-

*Presented before the County Medical Society Officers' luncheon,
115th Annual Session of the Medical Association, May 6, Savannah.*

MEDICINE AND RELIGION / Meadows

ceutical companies, and each year we have had very enthusiastic support from these companies. These annual programs have been attended by members of the Department of Medicine and Religion of the American Medical Association in Chicago and have been reported in such publications as *The Medical Tribune* and *The Journal of the Medical Association of Georgia*. Our 1969 Symposium will be featured in the June, 1969, issue of the *Atlanta Magazine*. These programs have required a great deal of work, but we feel that they have been worthwhile in every way and have been most remunerative, mainly in personal relationships in our being able to enter into a dialogue with the lawyers and clergymen in our community. The 1969 Symposium this year was co-sponsored by Kennesaw Junior College, which very graciously has joined our effort in affording clerical assistance, the location for the Symposia to be held, etc., which has enabled this young educational institution to enter into real dialogue with the adult members of our community.

In addition to the above annual programs, we have continued with quarterly programs with the local Cobb Judicial Circuit Bar Association and the local Cobb-Smyrna Ministerial Association. The quarterly programs which we have had for the past 12 months have included one in July, 1968, with the subject being "The Role of the Legitimate Theater in Contemporary Society," and the speaker for this was Mr. Jay Broad, director of Theatre Atlanta. Following this program, there was a panel discussion including a physician, lawyer, and clergyman. In October, 1968, our speaker was Dr. Leo Rippy, Jr., Professor at Scarritt College in Nashville, Tennessee, who spoke on "Learning to Love in Adolescence." On the same afternoon, Dr. Rippy conducted, under our sponsorship, a two-hour workshop on this same subject, which was attended by all the counselors and a great many of the principals and teachers in the Marietta and Cobb County School Systems. In January, 1969, the speaker at our quarterly meeting was the Professor of Humanities of our local Kennesaw Junior College, with the subject being "Moral Imperatives in Our Contemporary Society."

P. O. Box 506

CALENDAR OF MEETINGS

In Georgia

- Jan. 11-14—Society of Thoracic Surgeons, Regency Hyatt House, Atlanta.
- Feb. 8-10—American Society for Aesthetic Plastic Surgery, Marriott Motor Hotel, Atlanta.

In the Nation

- Nov. 30-Dec. 3—American Academy for Cerebral Palsy, Caesar's Palace, Las Vegas, Nev.
- Nov. 30-Dec. 3—American Medical Association (Clinical Convention), Denver, Colo.
- Nov. 30—National Conference on the Medical Aspects of Sports, Cosmopolitan Hotel, Denver, Colo.
- Nov. 30-Dec. 5—Radiological Society of North America, Palmer House, Chicago, Ill.
- Dec. 2-5—Reticuloendothelial Society, Jack Tar Hotel, San Francisco, Calif.
- Dec. 4—American Epilepsy Society, Roosevelt Hotel, New York, N.Y.
- Dec. 5-6—American Rheumatism Association, Pioneer Hotel, Tucson, Ariz.
- Dec. 5-7—American Academy of Psychoanalysis, Hotel Roosevelt, New York, N.Y.
- Dec. 6-11—American Academy of Dermatology, Americana, Bal Harbour, Fla.

- Dec. 7-9—American Society of Hematology, Sheraton Hotel, Cleveland, O.
- Dec. 8-10—Southern Surgical Association, The Homestead, Hot Springs, Va.
- Dec. 10—Annual Thyroid Workshop, Detroit, Mich.
- Jan. 9-18—International Fertility Association, U.S. Division, North American Conference of Fertility and Sterility, Dorado Hilton Hotel, Dorado, P.R.
- Jan. 16-17—American Society for Surgery of the Hand, Palmer House, Chicago, Ill.
- Jan. 17-22—American Academy of Orthopedic Surgeons, Palmer House, Chicago, Ill.
- Jan. 18—Mid-Winter Convention in Ophthalmology and Otolaryngology, Statler-Hilton Hotel, Los Angeles, Calif.
- Jan. 21—Symposium on Cardiovascular Research, Los Angeles, Calif.
- Jan. 30-Feb. 1—Southern Radiological Conference, Grand Hotel, Point Clear, Ala.
- Feb. 8-9—Congress on Medical Education, Palmer House, Chicago, Ill.
- Feb. 14-18—American Academy of Allergy, Jung Hotel, New Orleans, La.
- Feb. 25-March 1—American College of Cardiology, Rivergate, New Orleans, La.

This recently described dermatologic disorder is not nearly so rare as originally presumed.

Lymphomatoid Papulosis

ROBERT M. FINE, M.D., F.A.C.P.,* *Decatur, and*
HAROLD D. MELTZER, M.D.,† *East Point*

IN THE JANUARY, 1968 ISSUE OF THE *Archives of Dermatology*, Macaulay¹ introduced the term lymphomatoid papulosis for the first time in the medical literature. This term was used to describe a new dermatologic disorder whose clinical and histologic features vary within certain limits and "whose claim to distinction rests upon the incongruity of a benign clinical course in association with the histopathology of malignant lymphoma."

The 41-year-old woman he reported had an eruption for three years which clinically resembled pityriasis lichenoides et varioliformis acuta, Mucha-Habermann's disease, yet repeated biopsies of her skin lesions showed malignant lymphoma. The patient remained in good health although lesions continued to appear and regress at random during the course of her illness.

In 1966, Verallo and Haserick² reported two similar cases of young women with eruptions clinically similar to Mucha-Habermann's disease which on biopsy also showed changes of lymphoma cutis. The clinical course of these two eruptions was benign with complete resolution occurring in both within a period of a few months.

We have recently had the opportunity of studying a man with an eruption of four years' duration characterized by self-healing lesions, yet multiple biopsies showed features of a malignant lymphoma (case II).

In reviewing our office files we found another case of a teenage male we treated in 1962 whose eruption was similar to the case reports previously cited.

Two skin biopsies showed "cutaneous vasculitis" with atypical cells suggestive of a malignant

lymphoma. We believe that these two cases, although differing in certain respects from each other and from those previously reported, deserve to be included in the broad clinical spectrum of lymphomatoid papulosis because of their benign clinical courses and malignant-appearing histology.

Case I

Case report: An 18-year-old white man was first examined in April, 1962.

He had a widespread papular, papulopustular and necrotic asymptomatic eruption which tended to heal spontaneously leaving varioliform scars. This had recurred every spring for the preceding 11 years and had no apparent adverse effect on his health.

He also had chronic tinea corporis and a positive delayed intradermal trichophytin skin test. Laboratory workup, including complete blood count, sedimentation rate, urinalysis, protein electrophoresis, and chest x-ray was within normal limits. A clinical diagnosis of allergic cutaneous vasculitis was made and two lesions were biopsied.

In both, a heavy infiltrate was present in the dermis which contained large atypical histiocytes suggestive of lymphoma, leukemia or mycosis fungoides. The intimate association with blood vessels, however, indicated that this was basically a benign reactive process akin to allergic vasculitis.

His lesions gradually cleared over a period of a few months only to relapse again in May, 1963. A recent telephone contact with his mother revealed that he continues to develop new lesions and remains in good health some five years later.

COMMENT:

At the time this patient was being treated the possibility that he had a lymphoproliferative malignancy had to be seriously considered on the basis of the biopsy. In spite of this, the benign course of

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the disease and continued good health of the patient mitigated against this diagnosis and chemotherapy was delayed.

Case II

Case report: For the past four years a 43-year-old white male has developed multiple asymptomatic, papular, nodular, papulonecrotic and ulcerative lesions localized to the arms, thighs, and mid-trunk. Many lesions have undergone spontaneous resolution leaving hyperpigmentation and superficial scars.

On physical examination only a few enlarged inguinal nodes were palpated; however, no other organomegaly was apparent.

Laboratory workup, including complete blood count, bone marrow, chest x-ray, IVP, biochemical profile, and VDRL was within normal limits. The bone marrow biopsy showed hyperplastic marrow. Old tuberculin intradermal skin test was positive. Biopsies of multiple skin nodules were initially considered diagnostic of lymphoma cutis. A hematology consultant after reviewing the biopsies felt that the patient had lymphoma, probably Hodgkin's disease and should be treated with chemotherapy. Before this could be started, the patient discharged himself and has been lost to follow-up.

The skin biopsies were submitted to two other dermatopathologists^{3, 4} and neither was willing to make an unequivocal diagnosis of malignancy in view of the long benign clinical course. They felt, however, that the infiltrate was distinctively atypical and strongly supported the diagnosis of malignancy.

COMMENT:

It is possible that this patient actually has a cutaneous lymphoma without evidence of systematization. The long course and self-healing nature of the lesions are strong evidence against this possibility as is the rarity of Hodgkin's disease appearing first in the skin.

Discussion

Although Verallo and Haserick were apparently the first to actually document the occurrence of an atypical lymphohistiocytic infiltrate with Mucha-Habermann's disease and a benign prognosis, it is fairly certain that others were aware of this association. As far back as 1962 the dermatopathologist (WHC)⁵ who read the biopsy from our case I, mentioned that he had in his files other examples of cutaneous vasculitis with a malignant-appearing infiltrate associated with a benign clinical course.

To Macaulay must go the credit for renewing interest in this syndrome and for coining the term

lymphomatoid papulosis which certainly seems to be the name which is now most widely accepted and used.

As so often happens when a "new" disease is described, there have been a veritable flood of reports of similar cases and it now seems certain that lymphomatoid papulosis is not nearly so rare as originally thought. At a recent meeting in New Orleans⁶ three new cases were discussed and it has been stated that a London Dermatopathologist is currently following about a dozen similar cases.

The three case reports in the English literature compare the clinical appearance of lymphomatoid papulosis to pityriasis lichenoides et varioliformis acuta and although there are certain similarities, significant differences are apparent.

We agree with Rook⁷ that Mucha-Habermann's disease is a distinctive polymorphic eruption showing many small discrete chronic appearing maculopapules with typical "wafer-like scales" in addition to the more familiar papulovesicular and papulonecrotic lesions. Apparently these chronic lesions do not merely represent a stage in the development of the acute lesions although at times they share similar histologic features. They generally arise *de novo* and clear independently without undergoing vesiculation or necrosis and are distinctive and quite characteristic of this eruption.

Chronic lesions similar to these were not present in either of our cases and were not mentioned by Macaulay in his report. We do not feel therefore that our cases or his should be classified as Mucha-Habermann's disease. The previously reported cases and our own seem to comprise a broad morphologic spectrum and it is likely that more than one clinical entity has been included. However, the histologic findings have been remarkably similar and tend to unify the group.

Conceivably, lymphomatoid papulosis does not have a specific clinical appearance which can be narrowly defined but actually represents a syndrome characterized by what may be a diverse clinical picture associated with a lymphomatous-appearing skin biopsy. The benign nature of the process is ultimately determined by the clinical course.

Unpublished Cases

It is also possible that some of the reported patients in reality have lymphoma if they are followed long enough as has one of E. Wilson Jones' unpublished cases.¹ In 1968 Potter, et al.,⁸ reported an 18-year-old woman with Hodgkin's disease beginning in the skin and persisting there for seven years before evidence of involvement of any other system appeared. The definitive diagnosis was not made until the patient was 25 years old and an enlarged in-

guinal node was excised. Following this lymphangiography demonstrated enlargement and apparent involvement of femoral, iliac, and periaortic nodes.

It is also interesting to note that angiitis with fibrinoid degeneration of blood vessels but without an atypical infiltrate was present in the biopsy of a nodule on the ankle at about the same time the positive lymph node was discovered. The association of vasculitis and other auto-immune phenomena with lymphoreticular and myeloproliferative malignancies is well documented⁹⁻¹¹ and cutaneous vasculitis may on occasion be the initial indication of systemic lymphoma.¹²

Careful evaluation of the histology of our cases suggests that lymphomatoid papulosis is basically a benign reactive process centered about small dermal blood vessels which may or may not show various degrees of intrinsic injury. It is possible that vasculitis is the basic underlying change in some of these patients. In this respect, there is a similarity to Mucha-Habermann's disease or to allergic cutaneous vasculitis.¹³ However, the presence of an atypical malignant appearing infiltrate is not a feature of these two conditions.

In summary, we are reporting two male patients with benign behaving eruptions lasting four to 18 years. Both had spontaneously self-healing lesions which showed histologic features of malignant lymphoma. We believe that these cases satisfy the criteria for the diagnosis of lymphomatoid papulosis proposed by Macaulay i.e., "a continuing self-healing eruption clinically benign, histologically malignant."

We have hypothesized that this is a benign reactive process characterized by vasculitis and possibly related to delayed hypersensitivity in which malignant-looking cells appear in response to profound antigenic stimulation of immune mechanisms.

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Until homo sapiens becomes more sapient I can see no prospect of his ever avoiding the foolishness of war or of his learning that two automobiles cannot occupy the same spot at the same time, especially when they come from opposite directions. Broken bones and lacerated wounds are therefore likely to require surgical attention for as long as this would-be clairvoyant can see into the future.

—Evarts A. Graham

After experience with the 50 cases reported in this paper, the author questions whether this radical approach is justified.

Jejuno-Ileostomy for Obesity

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INTESTINAL BY-PASS SURGERY is the only present treatment for obesity that always causes weight loss. The first reports of intestinal by-pass consisted of jejuno-colostomy.^{1, 3, 4, 6, 8, 12-14, 16} These produced marked weight losses but nutritional deficiencies and undesirable side effects led investigators to revise many of these cases producing jejuno-ileostomies.^{1, 6, 16} The problems encountered were how much jejunum and how much terminal ileum should be left functioning. If too much is used weight loss will not be obtained and if too little is used undesirable side effects and nutritional deficiencies will result.^{2, 16}

This is a report of 50 cases of jejuno-ileostomy

that were consecutive except for two cases in which follow-up observations were inadequate. The primary indications for surgery were obesity but every case had other disorders allied to obesity (see Table 1). The excess weight varied from 50 to 250 pounds as judged by conventional height-weight tables. The identical by-pass procedure was performed on all cases (Figure 1). The abdomen was opened and explored. The ligament of Treitz was identified and measuring with a tape along the mesenteric border of the jejunum, a point was picked 14 inches distally. The jejunum was divided.

TABLE 1
ADDITIONAL DIAGNOSIS BESIDES
OBESITY PREOPERATIVELY

	Number of Cases
Hypertension	13
Gouty Arthritis	14
Diabetes Mellitus	38
Angina Pectoris	1
Epigastric Hernia	2
Ventral Hernia	2
Hypercholesterolemia	15
Chronic Glomerulonephritis	1
Rheumatoid Arthritis	2
Umbilical Hernia	4
Fibromyoma Uterus	2
Psychiatric Mental Illness	2
Chronic Cervicitis	8
Varicose Veins	1
Cardiac Decompensation	2
Previous Pulmonary Embolus	1
Chronic Pyelonephritis	1
Chronic Thrombophlebitis	1
Degenerative Arthritis	2
Stasis Dermatitis Legs	1
Acute Cholecystitis	1
Chronic Cholecystitis	6
Retroversion Uterus	1
Left Ventricular Hypertrophy	1
Leutic Heart Disease	1
Paroxysmal Auricular Tachycardia	1
Adenocarcinoma Uterus	1

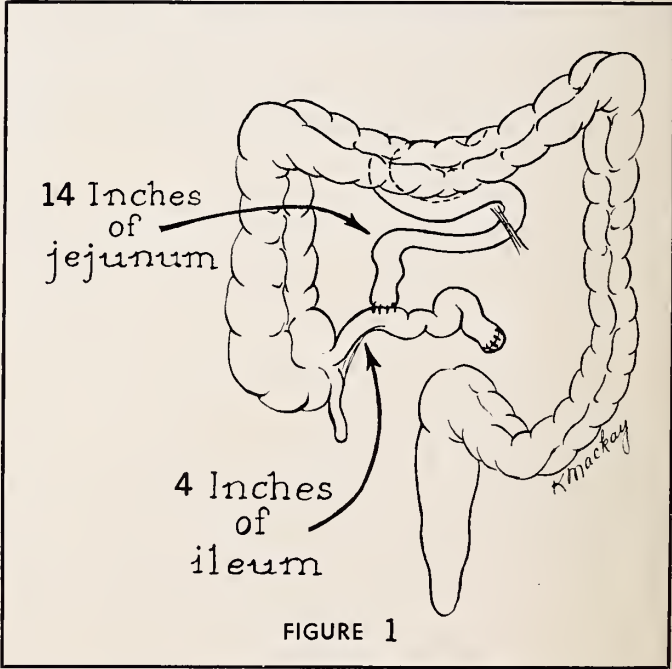


FIGURE 1

The distal end of the jejunum was inverted upon itself with one layer of interrupted inverting 4-0 silk suture. The proximal end of the jejunum was anastomosed to the terminal ileum at a point four inches above the ileocecal junction. This was a two-layer, end to side, anastomosis using interrupted 4-0 silk suture on the outer layer and continuous 3-0 gastrointestinal chromic catgut on the inner layer. In the first 28 cases the distal jejunum was

left free. In the last 22 cases the distal jejunum was plicated to itself for four inches with interrupted 4-0 silk sutures. This is a most important step in preventing intussusception of the blind jejunal pouch.^{5, 10} The incisions were closed in routine anatomical fashion with the addition of wide stainless steel stay sutures. This also is very important in preventing evisceration.¹⁶

Preoperative study included a complete history and physical, complete blood count, urinalysis, glucose tolerance test, cholesterol, uric acid, serum protein determinations, EKG and chest X-rays. Additional tests were done when an abnormality

was suspected. The patients were prepared with a low residue diet and neomycin sulfate-phthalysulfathiazole (neothalidine). This is most important in reducing the incidence of wound infections.¹⁶

Postoperatively intravenous fluids were given for 24 hours, then liquids by mouth followed progressively by soft and regular diets as progress dictated. Wire stay sutures were removed three weeks postoperatively if patients would tolerate them. Follow-up studies at three-month intervals were attempted and actually carried out about 50 per cent of the time.

TABLE 2

Patient	Age	Color	Sex	Height (Inches)	Weight Before Surgery	Weight After Surgery	Weight Loss	Time Since Surgery (Months)
1.	25	w	f	67	273	190	83	32
2.	32	w	f	68	182	106	76	6
3.	40	w	f	62	233	166	77	28
4.	28	w	m	73	287	185	102	27
5.	29	w	f	65	227	155	72	30
6.	42	w	m	69	252	204	48	29
7.	20	w	f	63	171	115	56	27
8.	26	w	f	55	236	211	25	27
9.	48	w	f	65	249	180	69	23
10.	57	c	f	64	231	150	81	25
11.	30	w	m	66	264	180	84	24
12.	49	c	f	63	210	124	86	24
13.	30	c	f	65	198	127	71	23
14.	52	w	f	62	191	153	38	24
15.	50	w	f	61	285	144	141	30
16.	21	w	f	60	160	120	40	24
17.	48	w	m	65	221	189	32	10
18.	38	w	m	69	342	212	130	23
19.	57	c	f	62	200	153	47	21
20.	28	w	f	61	203	140	63	18
21.	27	w	f	61	207	124	83	20
22.	50	w	f	60	150	132	18	19
23.	37	w	m	68	261	213	48	20
24.	39	w	f	66	285	164	121	17
25.	19	w	f	65	209	138	71	21
26.	49	w	f	69	251	153	98	17
27.	28	w	m	69	286	238	48	13
28.	46	w	f	65	221	197	24	5
29.	35	w	m	68	260	132	128	15
30.	39	w	m	70	332	226	106	17
31.	34	w	f	69	271	195	76	12
32.	37	w	f	66	197	136	61	12
33.	35	w	f	66	305	203	102	15
34.	34	w	f	64	198	182	16	18
35.	55	w	m	71	262	227	35	14
36.	55	w	f	64	212	132	80	17
37.	29	w	f	63	217	172	45	16
38.	55	w	m	72	348	—	—	—
39.	40	w	m	68	232	187	45	14
40.	42	w	f	62	193	174	19	16
41.	48	w	f	65	244	155	89	12
42.	23	w	f	64	232	145	87	11
43.	23	w	f	62	224	152	72	12
44.	48	w	f	65	177	129	48	10
45.	37	w	f	65	207	155	52	14
46.	55	w	m	68	337	—	—	—
47.	37	w	f	61	375	239	136	14
48.	39	w	f	68	194	145	51	13
49.	33	w	m	69	310	216	94	12
50.	28	w	f	68	375	225	150	13

Results: Table 2

All cases lost weight. Thirteen were judged as excellent. Thirty-two were judged as good. Two died in the early postoperative period. Three were judged disappointing.

Two of the three disappointing cases (34 and 40) had lost 50 and 100 pounds respectively shortly before their surgery. One physician reported one case in which this was purposely carried out. This would suggest that large weight losses should not be expected in this situation.

Metabolic Effects

Carbohydrate Metabolism—Thirty-eight cases had abnormal glucose tolerance curves (fasting or two-hour levels above 120 mgm/100 ml or peaking levels above 160 mgm/100 ml). Three of these required 25, 35 and 55 units of insulin respectively (cases 5, 23 and 47) to control blood glucose levels. Postoperatively these patients received no diets or insulin after the first few days. Numerous blood sugar determinations were all within normal levels.

Cholesterol Metabolism—Fifteen cases had elevated cholesterol levels preoperatively. Forty-nine cholesterol determinations were recorded on these cases three to 24 months postoperatively. Only one test was above normal. This particular case had three other postoperative tests that were within normal levels. Of the other 48, 22 were within normal levels (150-250 mgm/100 ml) and 26 were between 70-150 mgm/100 ml. The average reduction in all these cases was 149 mgm/100 ml per case.

Protein Metabolism—Preoperatively, the total protein levels were below normal values in four cases. During the postoperative period the total serum protein levels dropped below 6 gms/100 ml in 19 cases. Fourteen of these were between 5.5 gms/100 ml and 6.0 gms/100 ml. Five were between 5.0 gms/100 ml and 5.5 gms/100 ml. Two were slightly below 5 gms/100 ml.

Preoperatively, the serum albumin levels were normal in 23 cases and below normal in 25 cases. Two cases were not recorded. One hundred eighty serum albumin determinations were done between three and 24 months postoperatively. One hundred twenty-five of these were recorded as below normal and 55 were recorded as normal.

The serum globulin was recorded at the same time. Preoperatively, 43 cases were above normal, 5 were normal and 2 were not recorded. One hundred eighty determinations were done between three and 24 months postoperatively. One hundred fifty-nine were recorded above normal and 11 were recorded below normal.

Clinically, two cases were temporary problems. Only one case continues to be a problem. This patient does not like meat, eggs, or milk. Generally speaking, protein, albumin and globulin values were frequently abnormal preoperatively. Reversed A-G ratios were common. Postoperatively, the tendency toward reversal of the A-G ratio was considerably increased.

Uric Acid Metabolism—Preoperatively, 14 cases had clinical gouty arthritis. Four additional cases had elevated uric acid levels.

During the postoperative period 59 tests were performed on these 18 cases at three to 24 months' time. Fifty-four of these tests were within normal limits. Five tests were above normal limits but none of these were after nine months time.

Twelve of these 14 cases with clinical gout have remained asymptomatic without treatment. Two cases have had symptoms and treatments but of much less extent than before surgery. Similar results were found and reported in two other cases.¹⁶

Effects on the Liver—Liver biopsies were performed on all cases at the original surgery if the liver appeared grossly abnormal (except one). Biopsies were also performed on all cases (except one) in which the abdomen was opened during the postoperative period.

At the original surgery, cases 46 and 47 had pathological reports of cirrhosis and 49 of severe fatty metamorphosis. The liver of case 15 was described as large and yellow.

Postoperatively, at 22 months, case 15 had a pathological diagnosis of early cirrhosis. Case 18 at 14 months and case 9 at 21 months had a pathological diagnosis of fatty metamorphosis. Case 41 had biopsies at six and 12 months and pathological diagnoses of fatty metamorphosis. Case 10 at 16 months had a normal pathological diagnosis. Case 16 at 13 months had a normal-appearing liver and no biopsy was taken. Case 44 had interesting liver function studies (see Table 3).

Kidney Metabolism—Case 6 had renal calculi preoperatively. Cases 3 and 26 had chronic recurring genitourinary infections preoperatively. Postoperatively, Cases 3, 6, 26 and 39 passed renal calculi.

Physiological Effects

Blood Pressure—Thirteen cases had abnormally high blood pressure levels preoperatively. Postoperatively, nine of these cases were recorded at normal levels. Four cases remain unbenefited.

Electrolyte Problems—Twenty-two cases had clinical and laboratory evidence of serum potassium and calcium deficiencies. Obviously, additional mild deficiencies occurred without recogni-

TABLE 3

	Preoperative	Three Months Postoperative	13 Months Postoperative
1. Thymol Turbidity	13 Shank Hoagland Units	8.8 Shank Hoagland Units	4.3 Shank Hoagland Units
2. Hanger Test	4 plus at 48 hours	3 plus at 48 hours	negative
3. Total Protein	7.6 gms/100 ml	7.8 gms/100 ml	7.3 gms/100 ml
4. Albumin	3.45 gms/100 ml	3.9 gms/100 ml	4.8 gms/100 ml
5. Globulin	4.15 gms/100 ml	2.5 gms/100 ml	2.5 gms/100 ml
6. B.S.P.	30.8 per cent retention at 45 minutes		

tion. In a few instances intravenous replacement was temporarily required. Ultimately all were controlled with intermittent oral supplementation.

Pregnancy—Cases 8 and 25 delivered normal full-term pregnancies following bypass surgery.

Heart—Case 45 had paroxysmal auricular tachycardia. It was unaffected by the bypass.

Additional Surgery

At the time of the original surgery additional surgery was performed (see Table 4). In cases 5, 6, 19 and 21 this was the primary indication for surgery.

TABLE 4

1. Seven cholecystectomies
2. Eight hysterectomies
3. Four umbilical hernioplasties
4. Three ventral hernioplasties
5. One uterine suspension
6. One Meckel's diverticulectomy
7. One common bile duct exploration

Postoperative Complications

I. Directly related to the bypass surgery

1. Ventral hernia (Case 15 was repaired twice)—7 cases.
2. Wound infections—5 cases.
3. Eviscerations—1 case.
4. Atelectasis—2 cases.
5. Redundant abdominal apron of skin that collected edema fluid—1 case.

This was case 15. It was repaired by wedge excision of a section of skin 23 inches long and 8 inches wide at the time of ventral hernia repair and splenectomy. Splenectomy was done because of persistent thrombocytopenia.

6. Intractable diarrhea and intolerable stool odor—1 case.

Case 28 insisted and received re-establishment of normal bowel continuity five months after by-pass. She quickly regained her original weight and preoperative disabilities.

7. Due to a serum protein level of 5.8 gms/100 ml, a protein-bound iodine recorded at 12 mcg/100 ml and 126 pound loss, case 29 had normal bowel continuity re-established at another hospital.

8. Case 41 had normal bowel continuity re-established due to recurring attacks of fever, headache and vomiting that continued for one year. Intensive investigation failed to explain these episodes. Kidney biopsy six months after bypass was interpreted as normal and 12 months after the bypass was recorded as nephrocalcinosis. Four months following her re-establishment procedure her blood pressure was back up to 180/105, weight up to 190 pounds and other preoperative symptoms were returning.

9. Intussusception of the blind jejunal pouch occurred in three cases out of 28 that were not plicated at the time of the bypass. One of these required jejunal resection and the other two were reduced manually at surgery. There were no cases of intussusception in the 22 cases in which the blind jejunal pouch was plicated upon itself.

II. Indirectly related to the bypass

1. Symptomatic hemorrhoids severe enough to require hemorrhoidectomy—4 cases.

2. Case 13 had bleeding hemorrhoids severe enough to cause anemia and require 1,000 cc of whole blood by transfusion.

3. Tubercular cervical adenitis—2 cases.

One case (19) was an arrested tubercular preoperatively. The other case (36) was a nurse in a tubercular ward.

4. Case 23 had an acute gastrointestinal hemorrhage, cause undetermined that was managed by replacement of 2500 cc of whole blood.

5. Case 38 had ascending cholangitis four days postoperatively.

6. Death due to massive pulmonary embolus 24 days after surgery in one case (38) confirmed by autopsy.

III. Not related to the bypass

1. Death due to uncontrollable hemorrhaging esophageal varices in case 46 (confirmed by autop-

sy—patient also had pathological diagnosis of cirrhosis of the liver).

2. Case 17 was killed by an automobile accident 10 months postoperatively.

3. Case 12 had a third degree perineal laceration preoperatively. This, in addition to diarrhea following her bypass, was quite a problem until it was corrected surgically.

4. Pulmonary embolus occurred in case 47 seven months before her bypass and again eight months after her bypass.

5. Case 2 committed suicide seven months postoperatively. She was a schizophrenic who had psychiatric treatment before and after her bypass. She shot herself in the chest with a shotgun while on leave from the mental hospital.

6. Case 20 unsuccessfully attempted suicide both preoperatively and postoperatively.

7. Case 11 had severe acute glomerulonephritis 11 months postoperatively. He recovered completely.

8. Numerous emotional disorders.

Side Effects

Diarrhea was a temporary problem in practically every case. Diphenoxylate hydrochloride with atropine sulfate (Lomotil), calcium carbonate⁹ and fat-free diets were used extensively to control diarrhea. In a few cases carbohydrate restriction helped. A few required starvation and intravenous feedings temporarily.

By three months postoperatively 46 cases recorded six or less bowel movements and four recorded over six bowel movements a day. By 12 months postoperatively, 35 reported four or less bowel movements a day, five reported four to six bowel movements a day, three recorded six to 12 bowel movements a day and six were not recorded.

Discussion

Evisceration of the incision will be common unless additional support is used.¹⁶ In this series no eviscerations occurred when the stay sutures were left in for three weeks. One case eviscerated when the stay sutures were removed two weeks postoperatively.

Satisfactory weight losses were produced in 94 per cent of the cases. This is spectacular when compared to conventional methods of weight loss.

One physician reported a case in which he directed the patient in successful weight loss by dietary methods and then performed a bypass to keep the

weight down. This is an excellent method if it can be accomplished. Cases 34 and 40 were similar to this method even though they were not planned as such.

The metabolic effects were dramatic. Apparent relief from elevated blood sugars, marked lowering of the cholesterol and uric acid levels, when elevated, appears to be beneficial. Changes in serum protein values and liver biopsies are viewed with concern. Electrolyte deficiencies were only transient problems. Benefits in hypertensive cases were obvious.

The relationship of the bypass to renal calculi is unknown. Renal calculi formation in patients undergoing starvation for weight loss, who do not have adequate fluid intake, is well recognized. A similar situation is probably present in bypass cases.

Emotional factors are involved in many cases. Morgan¹⁵ noted that many unexplained symptoms are found in the postoperative period. Bypass is no cure for nervous illness. Personalities often are affected, some beneficial, some made worse, after marked weight loss.

Bypass surgery can easily be done at the time of other surgery such as hysterectomy, hernia repair and cholecystectomy. This might justify bypass in moderately obese people (weight excesses of 50 to 75 pounds.)

During the period of marked weight loss, which is primarily the first year, the natural body resistance to infections is reduced. Through this period extra precautions to prevent infections are indicated.

A few cases do not tolerate bypass well and will have to be revised or re-established. This can be easily accomplished.

Postoperatively, complications will be much higher than in normal weight subjects.^{10, 12, 17}

Obesity is a malignant disease with many sides. In treating obesity the entire mental and physical state must be considered. Bypass surgery is a very radical approach to this difficult disorder.

Much more investigation, experience, observation and long term follow-up are needed to determine whether or not this radical approach is justified.

Summary

Fifty cases of jejuno-ileostomy for obesity are presented. Preoperative studies demonstrated multiple disorders. Satisfactory weight losses were obtained in 94 per cent of the cases. Metabolic, physiological and emotional effects were discussed. Obesity is a malignant disease. This form of therapy is a very radical approach. Much additional investigation and longer follow-up studies are badly needed.

Doctors Clinic

J.M.A. GEORGIA

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HIGHLIGHTS OF THE MAG COUNCIL MEETING SEPTEMBER 20-21, 1969

This summary covers only major actions and is not intended as a detailed report in lieu of meeting minutes.

Adopted a resolution endorsing a continuing education program for nursing, proposed by the Georgia State Nurses Association.

Endorsed the plan of the Georgia Association of Pathologists for a workshop to explore a proposed Medical Examiner system in Georgia and commended the GAP on their approach.

Reaffirmed as proper previous actions establishing the process of electing MAG officers in the 1970 House of Delegates.

Authorized the Executive Committee to study proposals on licensure of laboratories and laboratory personnel at its October meeting.

Approved in principle the Department of Public Health plan to reduce the number of Public Health Districts from 38 to between 13 and 15, and commended Dr. Elton S. Osborne for his work as Assistant Director of the Department.

Approved the plan of the Department of Public Health on the use of the 140,000 doses of Rubella vaccine designated for Georgia by the Federal Government, and commended John E. McCroan, Ph.D. for his work on this problem. The plan provides for immunizing seventh and sixth grade females and first grade males and females.

Approved the following unbudgeted expenditures:
\$1,000 to the Convention Bureau in support of the National Conference of State Legislative Leaders, meeting in Atlanta in November.

Actual expenses up to \$250 for the Chairman of the

Committee on Medical Review and Negotiating to attend the National Conference on Review, Denver.

\$100 to the Committee on Review and Negotiating for 1969 revised editions of the California Relative Value Study.

\$675 for printing and mailing to all MAG members the "Principles Governing Physician-Lawyer Relationships."

Up to \$700 for expenses of the AMA delegation to the AMA clinical meeting, December 1-4.

Voted to extend the time limit for payment of 1969 additional dues.

Adopted the recommendations of the Executive Committee that the March, 1970, meeting of Council be held in Puerto Rico, and that the air fare of staff be prorated to Council members who attend.

Voted to express gratitude to Dr. Edgar Woody for his long service as Editor of the *JMAG* and to extend sympathy to him on the loss of his father.

Voted commendation to Dr. J. Frank Walker on being elected Vice Speaker of the AMA House of Delegates, and to Dr. F. William Dowda as Dr. Walker's campaign manager.

Heard letters referred through the AMA from a patient praising Dr. A. J. Hendrick of Perry and voted to commend Dr. Hendrick.

Accepted with regret the resignation of Dr. J. W. Chambers as Coordinator of the GRMP, and voted permission for Executive Committee to select his successor.

Accepted the invitation of the Fulton County Delegation to hold its next meeting in Atlanta, December 13-14.

Quo Vadis Bio-Engineering in Georgia?

SAMUEL B. CHYATTE, M.D., and J. D. WALTON, JR., *Atlanta*

NEARLY EVERY MAJOR MEDICAL and engineering center in the nation has felt the surge of interest in "bio-engineering" or "bio-medical-engineering." While terminology varies from center to center, basically the process being identified is the interaction of biological concepts, techniques, systems and materials with engineering or physical science concepts, techniques, systems and materials.

As in any natural process of evolution, the development of the field has had variable success and variable pathways of expression, dependent in large measure on local conditions. Often, individual projects progress unnoticed even among an investigator's colleagues. Yet, it is the individual investigator in collaboration with other individual investigators who must form the nucleus of a meaningful organized "program" in bio-engineering.

In order to better identify individual workers and to determine the extent of both current activities and interest in bio-engineering in Georgia, the Board of Regents of the University System of Georgia authorized the selection of a survey team to delve into these questions.

For convenience, the survey team elected to sample the potential bio-engineering community in the geographic area of Atlanta. A questionnaire was designed to determine persons currently active in or interested in bio-engineering and to identify problems which might productively be considered by the bio-engineering approach.

Because the academic community forms only a part of the scientific community in any geographic area, an attempt was made to reach private practitioners of medicine and dentistry as well as non-university based engineers. The survey team felt that any broadly-based bio-engineering cooperative venture would have to include the viewpoints of personnel who deal daily with the practical problems of their professions.

Three hundred and forty (340) responses indicating current activity or interest were received from the first questionnaire. From the types of activities,

interests and problems listed a panorama of bio-engineering could be discerned. The panorama is illustrated in Table I.*

Table I represents, in its horizontal components, the increasing complexity of organization common to both the physical and life sciences. Particles, forces, atoms and molecules are organized into materials with special properties, mechanisms and functions. These more basic components are applied as systems and procedures to deliver the product in usable form to the "consumer." On the life science side, molecules, cells and tissues are the units which are organized into organs and organ systems. Organ systems interact producing the functional organism. Organisms interact on a one to one basis or in groups. Two end results of the interaction are patient care or the delivery of health services.

Vertically, the physical sciences represented by the physicist, chemist and engineer blend with the life sciences represented by the biological scientist, physician and behavioral scientist to develop the biophysical sciences. Instrumentation, mathematical or other models of life systems and substitutes for structure or function also vertically cross the organizational layers.

Activities at all vertical and horizontal levels are currently in progress in Atlanta. Some projects already involve inter-disciplinary effort; others evidence a desire to obtain inter-disciplinary assistance. When professional disciplines intermingle, communications are usually the major initial problem. Even members of the same discipline in the same institution or in the same community seldom have adequate communications. Technical jargon, the deluge of printed material (alias logorrhea), and the lack of awareness of the presence of a project related to one's own all contribute heavily to the problem.

* The concept of a panorama was originally proposed by Heber J. R. Stevenson, Sc.D., Division of Research Grants, National Institutes of Health, at a Bio-engineering seminar at the Georgia Institute of Technology on November 22, 1968.

		PHYSICAL SCIENCES		BIOPHYSICAL SCIENCES			LIFE SCIENCES			
COMPONENTS	BASIC	PARTICLES & FORCES	PHYSICIST	INSTRUMENTATION (Research Development and Application)	MODELS	SUBSTITUTES	BIOLOGICAL SCIENTIST	MOLECULES	BASIC	COMPONENTS
		ATOMS						CELLS		
		MOLECULES						TISSUES		
INTERNAL ENVIRONMENT		MATERIALS & PROPERTIES	CHEMIST				PHYSICIAN	ORGANS & ORGAN SYSTEMS		MAN AND HIS INTERNAL ENVIRONMENT
		MECHANISMS & FUNCTIONS						ORGAN SYSTEMS INTERACTION		
								ORGANISMS & ORGANISM INTERACTION		
ENVIRON- MENTAL INTERACTION	APPLIED	SYSTEMS	ENGINEER				BEHAVIORAL SCIENTIST	PATIENT CARE	APPLIED	MAN AND HIS EXTERNAL ENVIRONMENT
		PROCEDURES						GROUP INTERACTION		
		DELIVERY						DELIVERY OF HEALTH SERVICES		

TABLE 1

In order to enhance the process of interchange of ideas and to alert potential colleagues to each other's existence, it was decided that a series of seminars (privately dubbed the "Tower of Babel Seminar Series") would be a logical first step. Using the panorama chart as a basis, the following seminars were outlined:

I. CELLS AND TISSUE

- A. Function and Structure
- B. Submolecular and Molecular Properties
- C. Substitutes or Modification
- D. Instrumentation

II. FLUID SYSTEMS (Biological)

- A. Fluids
- B. Conduits
- C. Pumps
- D. Filtration Systems
- E. Substitute Parts and Systems
- F. Instrumentation

III. MOTOR PERFORMANCE (Biological)

- A. Neuro-Muscular-Skeletal Basis
- B. Substitutes
- C. Monitoring and Instrumentation
- D. Motor Performance of Individuals and Group Interaction Based on Motor Performance

IV. HEALTH CARE SYSTEMS

- A. Health Related Procedures and Their Delivery

- 1. patient or health professions transport
- 2. patient flow and/or care flow
- 3. automation and mechanization
- B. Physical Plant and Equipment
 - 1. plant design
 - 2. equipment design and utilization
- C. Economics
 - 1. management (systems analysis, cost decision, information storage and retrieval, manpower)
 - 2. insurance
- D. Social Factors
 - 1. community planning
 - 2. individual and group health factors

V. INSTRUMENTATION

- A. For Biological Studies of:
 - 1. cell, tissue and organ structure, function and performance
 - 2. organ system function, performance and interaction
 - 3. organism function and performance and interaction of organisms and groups
- B. Instrument Research and Development
 - 1. properties and behavior of instrument materials in contact with biological systems
 - 2. properties and behavior of instrument components in contact with biological systems
 - 3. mechanism and function of instrument components and systems
 - 4. procedure for instrument operation

- 5. manufacture and delivery of instruments and instrument systems

VI. MODELS

- A. Cells and Tissue
- B. Fluid Systems
- C. Health Care Systems
- D. Motor Performance
- E. Computer Applications

VII. SUBSTITUTES

- A. Artificial Organs or Parts
 - 1. Functional
 - a. kidney, heart, etc.
 - b. limbs
 - c. eyes, ears, palate
 - 2. Cosmetics
 - a. facial, ocular, aural, oral
 - b. breast
 - c. other
- B. Artificial Cells, Tissue, Fluids, Including Replacements for:
 - 1. blood
 - 2. skin
 - 3. bone
 - 4. teeth
 - 5. hair
 - 6. other
- C. Materials
 - 1. preparation
 - 2. properties and behavior
- D. Psycho-Social Reactions to Artificial Parts

The seminars were projected to begin in September, 1969.

The respondents who had indicated current activities or interest were surveyed again. They were asked to indicate which seminar(s) would be of interest and most closely related to their own current efforts. Two hundred and eleven (211) responses were received from the following sources:

1. Emory University	92
a. Physicians (part-time faculty)	46
b. Physicians (full-time faculty)	22
c. Dentists	2
d. Arts and Sciences	12
e. Basic Sciences	5
f. Yerkes	5
2. Georgia Institute of Technology	72
a. General College	14
b. Engineering College	34
c. Engineering Experimental Station	23
d. Administration	1
3. Georgia State	5
4. Lockheed	3
5. Scientific Atlanta	1

6. Non-Emory Physicians	26
7. Non-Emory Dentists	12

Interest in each seminar was generalized. Many respondents indicated more than one area of interest.

Seminar Title	Number Indicating Interest
I. Cells and Tissue	58
II. Fluid Systems	48
III. Motor Performance	57
IV. Health Care Systems	93
V. Instrumentation	106
VI. Models	85
VII. Substitutes	74

And now, "Quo Vadis?" In the 1969 session of the General Assembly of the State of Georgia, "An Act to Create the Institute for Research in Bio-Technology (S.B. 263)" was passed. The bill authorized the State of Georgia to financially support in part a Bio-Technology Institute during its first three years of existence with the following objectives:

"The institute shall conduct research and generally explore and promote the combination of medical and engineering sciences and related fields of science. It shall be the objective of the institute to find new ways in which physical and engineering disciplines may contribute to improved health and longer life through such developments as artificial and substitute organs; the application of engineering experiences in physics and chemistry to body processes; the accommodation of the human body to new and varied environments; and to other biological-technological interfaces. The institute may undertake basic research to add to the store of human knowledge; but it is specifically encouraged to work in areas of applied research which may lead to the establishment of new industries and the creation of new jobs in Georgia."

Certainly, then, the political, academic and community climate is favorable for "bio-engineering" growth and development. But what kind of growth, and development in which directions?

One pathway to the future might be to simply let things go as they now are. Individual investigators working in blissful ignorance of fellow investigators' related undertakings, sometimes duplicating each other's failures and successes, incompletely capitalizing on the advancements of others to promote one's own project, and each investigator seeking inter-disciplinary collaboration only when desire and opportunity coincide. Despite these drawbacks,

such a system has proven "productive," if not "efficient."

An alternate pathway might seek ultimate "efficiency." All investigators gathered together in a glittering institute crammed full with sophisticated equipment, expertise and instant consultation. Information transfer systems, toilet facilities, and hardware all in orderly stacked units. The investigator no longer owing allegiance to a home university or corporation is freed from financial and administrative tentacles. Yet, in time, the individual drifts from his original discipline and instead of the chemical engineer becomes the bio-engineer. The unique viewpoint and background which made him different from the other engineers who came to the institute tends to blur. The institute develops the administrative or financial complications of the university or corporation. Communication with those outside of the institute becomes more difficult. Perhaps most critical, such an institute does not grow out of the demands of the investigators; it usually is superimposed upon them. It is rarely designed by the workers, but the workers function within its limitations. Perhaps, then, it would not be prudent to seize upon the opportunity for a Bio-Technology Institute of this type at this moment.

An organized cooperative bio-engineering venture is in its infancy in Georgia. It is beginning to express natural directions of growth. Given a forum for the interchange of ideas and communications in general, the individual may profit from the efforts of others but retain his identity and unique qualities. In time, individuals will gradually coalesce into functioning cooperative units. When such units become complex enough so that they seek a combined base of operation, it will be appropriate to seek sophisticated institute-like organizations.

But, the moment for action must not slip by unnoticed and without response. The explosive impact of bio-engineering upon the nation's scientific and economic frontiers demands prudent but tangible action from the Georgia community if it is to be a pioneering participant rather than a spectator.

Now is the time to capitalize upon the excellent but embryonic syncytium which has been identified. Now is the time to accelerate the rate of growth, while maintaining the natural developmental options.

As a vehicle for action, the following is proposed:

1. That there be established a Georgia Congress

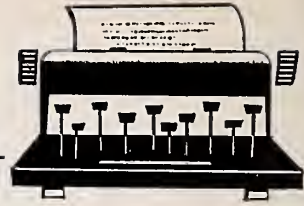
for Bio-engineering composed of representatives from

- a. The Georgia Institute of Technology
 - b. The Emory University School of Medicine
 - c. The Medical College of Georgia
 - d. The Georgia University System
 - e. The Emory University
 - f. The industrial community
 - g. The medical and dental community
 - h. Physical and Life Science disciplines
 - i. State and local legislative bodies
- those units not included in A, B, or C
2. The Congress would be charged with the following responsibilities:
- a. To assist individuals in the processes of grant writing and the identification of sources of research funds.
 - b. On an inter-institutional level, it will act as a body for the evaluation of projects seeking federal and state funding.
 - c. As a monitor of national and state trends in bio-engineering, it will focus the attention of individuals or groups within the state upon any opportunities which may be thus identified. It will then be the instrument through which talents and facilities from various sources are utilized optimally in responding to the identified opportunities.
3. In order to discharge the above responsibilities, the Congress will:
- a. Develop and maintain a registry of all bio-engineering projects in the state, including title, synopsis, investigators and key word index.
 - b. Develop and maintain a list of persons in the state willing to act as consultants to bio-engineering projects with data as to areas of expertise and previous investigative or other efforts.
 - c. Develop and maintain a state-wide newsletter which reports current bio-engineering activities, pertinent current legislation, grant sources, etc.
 - d. Maintain the bio-engineering seminar program already initiated.

In addition, it is suggested that the members of the Medical Association of Georgia request the formation of a bio-engineering subcommittee which then would act to represent and protect the interests of the physician within the Congress of Bio-engineering.

No wise man ever wished to be younger.

—Jonathan Swift



From Potty to Pot—A Giant Leap Backwards

DOCTORS AND PARENTS ARE BECOMING INCREASINGLY DISTURBED about the use of drugs by high school students in Atlanta. Perhaps we are not all aware that this problem exists, but it is present and increasing. It is interesting that a majority of high school students using drugs are in the more affluent schools. Probably about 2 to 3 per cent of high school students in these schools use drugs fairly regularly. Many others try them on occasions. Most of the students that get involved with drug use are members of the hippie groups. It is unusual, and indeed rare, for the athletes or the students who are involved in school activities, to use these drugs. The commonest drugs used are marijuana, LSD, and "speed" (amphetamine-dexedrine groups). Very few of these students have used "hard drugs" (heroin, demerol, morphine). These drugs apparently are obtained by the high school students from either the hippie colony or from servicemen who have returned from Vietnam, who bring the drugs back into this country. The drugs are also distributed by drug pushers, particularly to the hippie colony.

We live in a tense society—financially secure, but emotionally insecure. Fifty per cent of the adult population uses drugs at one time or another. The commonest drug, of course, is alcohol, but many adults are also hooked on tranquilizers, sedatives, and amphetamines. All of us feel the need, at times, to relax, unwind, gain confidence, or escape. Society now approves all of the drugs that we take, if the drugs are legal. It is no wonder, then, that the youth in our society also feel this tension and the need for escape. The teen years are very tense years. There is the constant threat of war and annihilation. It is impossible for us, both adult and youth, to change reality, so we seek to change our relationship to reality.

The young people that turn to drugs usually are those who are not motivated, and not challenged. In the large ghetto areas, these young people become frustrated and rebel against society because they cannot escape from an impossible situation. The more affluent young people who turn to drugs usually do so because they have nothing to strive for. They have everything that they want and need and they rebel against the so-called establishment, which they consider false. They cannot relate to the adult world, which, they feel, has a false sense of values. Many of them feel indignant because of the inequality of man. They feel that they cannot change life as they see it, so they withdraw from it and become a member of a group to which they feel they can relate. They do not find alcohol an adequate escape, because this is part of the establishment and is not condemned by their parents. The use of drugs by their peer group is a fad that is sweeping the country, and they are ready to try anything that will make them have a feeling of belonging.

What can we as parents and physicians do about this dilemma? Of course, we should inform our young people about the dangers of drugs, and make sure that they are aware of the results of their use. This is about as far as we can go with a direct approach. They will listen to responsible members of their peer group more

readily than they will listen to us, so this avenue should be used. More can be accomplished if we take an indirect approach, by offering them love, understanding, and acceptance. We should re-evaluate our own lives, and re-establish our own sense of values. We must be sure that our moral standards are real. Our children know more about us than we think they do.

H. Luten Teate, Jr., M.D.

FIFTH ANNUAL RURAL HEALTH CONFERENCE HELD

The Fifth Annual Rural Health Conference was held September 10 and 11 at the Alpine Lodge in Macon. Jointly sponsored by the MAG Committee on Rural Health and the Georgia Farm Bureau Federation, it was designed to inform registrants of some of the current problems facing rural Georgia and how many of those problems might be solved.

Thomas N. Lumsden, M.D., Chairman of the MAG Committee on Rural Health, presided.

Dale Clark, Director of Public Affairs for WAGA-TV, was the keynote speaker. He said there should be an awareness of the changing medical needs in Georgia, saying that there is a critical need for personnel in all areas of the State, especially in rural areas. Clark reported that on a national average, there are 300 nurses per 100,000 population, but in North and South Georgia there are only 99 nurses per 100,000 population.

During 1950, 7 per cent of the girls graduating from high school were entering nursing school, but the percentage has declined to less than 4 per cent. He did say, however, that much progress has been made to better supply the health needs of our state. For the past 15 years, an attempt has been made to locate more physicians in rural areas. A movement is now underway by the State Health Department to reduce the number of health districts from 38 to 15 throughout the state, Clark said.

Traffic Safety

Fleming L. Jolley, M.D., Chairman of the MAG Committee on Traffic Safety, gave a presentation on "Emergency Highway Care—Standards and Legislation." He said surveys and reports by the American College of Surgeons' Committee on Trauma showed that one-half of those involved in traffic accidents in rural areas and one-fifth of the accident victims in urban areas could have been saved from death, had competent and timely emergency medical services been rendered.

If these percentages were applied to the State, 694 lives from rural areas and 78 from urban areas could have been saved during 1968. A film on traffic safety was also included in the presentation. Discussion followed, with many questions coming from the floor related to emergency ambulance service and safety legislation.

"Traffic Safety in the Trucking Industry" was the topic of a presentation by Charles L. Skinner, Manag-

ing Director of Georgia Motor Trucking Association. Many trucking companies maintain their own safety department with a full-time safety supervisor, Skinner said. Truck drivers, highly-skilled and highly paid employees, have an opportunity to participate in many driver-incentive programs as well as being tested and having periodic physical examinations, he said.

Glen Garrison, M.D., faculty member from the Medical College of Georgia, discussed the role of the Medical College of Georgia in training Family Physicians. Among his topics of discussion were the prerequisites for improving delivery of personal health service and recognition of the problems and current status of training in family practice.

Changing Requirements

John McCroan, Ph.D., Director of the Epidemiologic Investigation Branch, Georgia Department of Public Health, discussed changing requirements in immunization and dog control regulations. Joseph Wilber, M.D., Director of Cardiovascular Disease Control, Georgia Department of Public Health, gave a presentation on Cardiopulmonary Resuscitation, stressing the importance of statewide training on this topic.

William Hansell, Director of the Air Quality Control Board, Georgia Department of Public Health, discussed the causes of air pollution and steps that may be taken to correct them. Water pollution was covered by Ralph Howard, Jr., Executive Secretary of the Georgia Water Quality Control Board, and Solid Waste was the topic of Jerry W. Brittingham, Environmental Technologist, Georgia Department of Public Health. During the presentation on environmental pollution the participants were shown what Georgia is doing to prevent pollution, and what they could do to help.

A few years ago, only 10 per cent of Georgia had adequate sewage disposal, but that figure has now risen to 22 per cent. Counties may request financial assistance to provide local sewage for cities and counties.

Robert Hanie, Director of the Georgia Natural Areas Councils; Miss Cerie Brannen, State 4-H Health Winner, and Mrs. Martha Jones, State Home Economics leader, also made presentations to the Conference.

Over 100 persons attended, representing state and local organizations. Plans are being made to hold the 1970 Conference on September 9-10, also at the Alpine Lodge in Macon.



THE MAG FOUNDATION

ABOUT A YEAR AGO ON THIS PAGE the President of the Medical Association of Georgia told us of the MAG Foundation, its objectives and what it could mean to us and to medicine in our great State. I call your attention to this fine article and, at risk of being repetitious, I use this page again to call the Foundation to your attention.

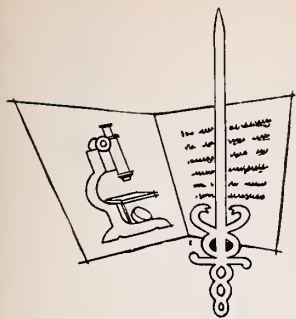
A Foundation is defined as an institution through which private wealth is contributed for public purpose; they have been with us for centuries. The Greeks and Romans formed them to honor their deities; Andrew Carnegie and John D. Rockefeller in this country led the way in creating Foundations to distribute their wealth and these and other Foundations have existed as depositories for monies that people wish to give to worthy projects. So far, they have been able to receive, hold and then pass on to worthwhile organizations these monies without governmental or other intervention.

The duly-elected leaders of the Medical Association of Georgia in 1967, being interested in promoting MAG activities that would go beyond operational procedures, and seeking a way whereby money could most easily be collected and passed on to our medical schools, needy medical students, or to help any project which would improve the practice of medicine in the State, formed the MAG Foundation.

Going into its third year, the Foundation is still in its infancy and, as an infant, needs the support of all of us. After the Foundation has come of age this support can be in the form of advice or executive aid in its administration, but until such time as it comes of age financially, the needs of the Foundation are the same as those of any organization trying to get started—financial assistance—and this is where each of us can help it along. Just as “little drops of water, little grains of sand make a mighty ocean and a pleasant land,” many small contributions to the Foundation will add up to a sum large enough to be steered into channels where it can and will be of untold benefit. Each of us each year puts aside a certain per cent of our income for our favorite charities and good works; the work of the Medical Association of Georgia should be among our prime interests and if each of us each year puts aside a small amount of money (or a large amount if he is so inclined) for the MAG Foundation, which money can be earmarked for a particular project if he sees fit, soon the Foundation will be of age and of such a size that it can carry out the intent of its founders, “fostering and promoting MAG obligations that go beyond operational procedures.” In other words, helping ourselves to help others to aid and abet the practice of medicine and thereby helping the State of Georgia and its people.

A handwritten signature in dark ink, reading "John Kirk Train". The script is fluid and cursive, with a large initial 'J'.

*John Kirk Train, M.D.
President, Medical Association of Georgia*



CANCER OF THE BREAST

A. H. LETTON, M.D., F.A.C.S., *Atlanta*

STATISTICS SHOW THAT THE MORTALITY RATE from breast cancer has not changed over the last 25 years. The statement has caused great concern to us who have been involved in the public education endeavors of the American Cancer Society. We have, for years, stressed that the earlier cancer is discovered and the earlier it is treated, the greater is the chance of cure. We have, by all means possible, attempted to induce women to practice self breast examination. We have evidence that women are discovering lumps earlier now than they did 20 years ago—so the statement that the mortality rate has not changed has bothered us.

Unfortunately there are but few areas in the United States where all cancers are routinely reported. Connecticut was the first state to establish a population-based registry 34 years ago. Using the incidence rates in Connecticut for the years of 1935 to 1939 and from 1960 to 1964, we find that during this time breast cancer has increased about 45 per cent in women less than 55 years of age, yet has remained relatively constant in those over 55 years of age. This increased incidence is sufficient to explain the constant mortality rate of cancer of the breast in spite of earlier diagnosis and improved therapy. In other words, more women are being exposed to the danger and more are being cured, yet the number of those succumbing to the disease remains coincidentally constant.

We do not know why cancer of the breast has been increasing in recent years, but we can speculate with some certainty. Feinleib has suggested: "We believe that the shape of the age-specific mortality curves can be explained by a fairly simple physiological hypothesis. In most women the susceptibility to cancer of the breast increased uniformly with age and upon this risk there is superimposed an additional risk which is proportional to the frequency and quality of ovarian function." Available statistics do not indicate marital status, fertility, or indices of hormonal function. However, the evidence from vital statistics showing a change in the risk of breast cancer coinciding with the menopause when there is a decreased ovarian function, points in this direction. The protective effect of marriage, high parity, and early artificial menopause in lowering this risk further corroborates this theory. He further states that there is accumulating evidence that adolescent females tend to menstruate earlier and develop secondary sex characteristics at a younger age than their mothers. With the earlier initiation of ovarian function these women will have a higher age-specific risk than the previous generation. Since they have longer menstrual lives they are exposed to ovarian function over a longer period of time and thus the threat of cancer of the breast is greater.

This study pretty well shows that the breast self examination program is, in reality, accomplishing much in saving additional lives from breast cancer. This program however depends on a woman examining her own breasts visually and by palpation. This obviously means that if the tumor is large enough for her to palpate

it has been growing some time. Certainly if there are skin changes the tumor is in a relatively advanced stage. Since 95 per cent of the women present themselves for treatment because they have found the lump themselves, we are really dealing with a group of patients who, instead of having early cancer of the breast, have been harboring cancer for an undetermined period of time. It therefore behooves us to continue to emphasize self breast examination and remove these tumors at the earliest possible moment until such time as a method of diagnosing cancer of the breast in an early stage is discovered, that we may use it to control breast cancer with the same effectiveness as we are controlling cancer of the cervix with Pap smears. Mammography can diagnose cancer of the breast very early but at the present time it is not practical or economically feasible to subject wide sectors of our women to the examination. In fact just to examine only the high risk group is a rather insurmountable task.

340 Boulevard, NE

Surgeons and anatomists see no beautiful women in all their lives, but only a ghastly stack of bones with Latin names to them, and a network of nerves and muscles and tissues inflamed by disease.

—Mark Twain (Samuel L. Clemens)

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THE MANAGEMENT OF ASYMPTOMATIC ABDOMINAL AORTIC ANEURYSMS

CHARLES H. WRAY, M.D., *Augusta*

PRIOR TO 1950, NEARLY ALL ABDOMINAL AORTIC ANEURYSMS were symptomatic when discovered, and the likelihood for long term survival was very low. In the classic report of Estes in 1950, patients with untreated abdominal aortic aneurysms were found to have survival rates of 67, 49, 19 per cent at one, three, and five years after diagnosis; but the relationship between the size of the aneurysm and mortality was not evaluated. In 1962, Schatz found that most aortic aneurysms less than 4.5 cm. in diameter were not palpable and that none of these patients died of ruptured aortic aneurysm. As the size of the aneurysm increased the incidence of rupture increased. Fifteen per cent of aneurysms with a diameter of 4-7.5 cm. ruptured, and 50 per cent of these with a diameter over 7.5 cm. ruptured within two years. However, some small aneurysms have ruptured.

The median age for patients with abdominal aneurysm is 65 years, and the frequency of associated cardiovascular disease is high. Approximately 40 per cent of these individuals are hypertensive. Arteriosclerotic heart disease with evidence of old myocardial infarction, angina pectoria, and congestive failure is common. Cerebrovascular insufficiency, arterial insufficiency of the lower extremities, and aneurysms in other locations are often found. The presence of associated diseases decreases long term survival, but 50 per cent of surgically treated patients are alive after five years in comparison with 9 per cent survival if untreated. Furthermore, among individuals without hypertension or heart disease, the five-year survival of 75 per cent of patients treated surgically for aneurysm approaches that of the normal population.

It is important to establish the size and extent of the aneurysm. In evaluating the size as determined by palpation, the thickness of the abdominal wall should be considered. The mass may extend high in the epigastrium without involving the renal vessels. Sometimes a pulsation is felt far to the left of the midline without the total width of the aorta being increased; this combination of findings usually indicates a very elongated tortuous vessel rather than an aneurysm. The normal abdominal aorta is about 2 cm. in diameter. Calcification in the wall of the aorta will allow measurements radiographically, and the size is more accurately determined from the lateral roentgenogram of the abdomen. Arteriog-

raphy is used more to evaluate the distal circulation and to determine renal artery involvement than to establish the diagnosis or size of the aneurysm.

It is now very common for an aneurysm to be found prior to any symptoms. In Estes untreated group only 10 per cent had symptoms. Among patients treated surgically at the Medical College of Georgia about 50 per cent are asymptomatic. The available information indicates that nearly all abdominal aortic aneurysms should be resected. The overall surgical mortality is low, and surgical therapy provides a much longer life expectancy than that of patients with aneurysms not treated surgically. Our experience indicates that less than 10 per cent of patients have such severe associated disease that they cannot be managed surgically. A few selected patients with relative contraindications to surgery and small aneurysms may be followed at six-month intervals and operated upon if the aneurysm increases in size or symptoms develop. The younger patient who has a small aneurysm and no associated disease should be managed surgically since the risk of surgery is small, and there is considerable chance of rupture or expansion. The mortality after rupture may be as high as 50 per cent.

There are several factors that may affect the timing of surgical intervention. Appearance of symptoms should hasten preparations. Urgent surgery would be required if any symptoms suggesting expansion or rupture appeared. A thorough evaluation of the patient may uncover some important cardiac, pulmonary, or renal problems that could be improved by therapy prior to surgery. Attention to such potential problems has produced a decrease in morbidity and mortality. A recent myocardial infarction in an asymptomatic patient is valid reason for delay.

In summary, the wiser course in most patients with abdominal aortic aneurysm is elective resection and grafting.

Medical College of Georgia

ADVICE TO FIRST-YEAR MEDICAL STUDENTS

*You will have to learn many tedious things, . . .
which you will forget the moment you have passed
your final examination, but in anatomy it is better to
have learned and lost than never to have learned at all.*

—W. Somerset Maugham



“RESTRICTIONS ON PHYSICIANS’ HOSPITAL PRIVILEGES”

JOHN L. MOORE, JR., *Atlanta**

A DECISION OF THE SUPREME COURT OF GEORGIA handed down on October 1, 1969, reiterates the overall control of privileges of staff physicians by the hospital governing board.

A physician duly licensed to practice medicine and surgery in Georgia applied for staff membership at a county hospital organized under the Hospital Authorities Act of 1943. The particular hospital used an elaborate application form which required the applicant to check the different treatments and procedures he wished to perform upon his patients admitted to the hospital. The particular applicant checked a majority of all of the treatments and procedures listed.

The medical staff of the hospital recommended admission of the applicant to staff membership but turned down some 25 of the procedures applied for, mostly procedures in the field of surgery. However, the staff recommended granting the applicant's request for more than 90 particular treatments and procedures. The Board of Trustees of the hospital confirmed the action of the medical staff.

Under the procedures established at the hospital, the Administrator next advised the applicant of the granting of his application and its conditions. The Administrator also requested the applicant to sign a required statement of agreement to abide by the bylaws, rules, and regulations of the hospital authority and the medical staff. The physician added language to the form which had the effect of asserting his position that any restrictions on his privileges to practice in the hospital were against the public interest, the laws of Georgia, and the Constitution of the United States. The physician then refused to abide by the restrictions imposed by the medical staff and the hospital authority. This finally resulted in his being denied all privileges at the hospital.

Thereafter, the physician sued the hospital, the hospital authority, and various official members of the hospital and hospital authority in their official capacities and as individuals both to recover damages and seeking an injunction to prevent the hospital and hospital authority and the individuals from restricting his privileges.

Issues in the Litigation

The plaintiff physician maintained in the litigation that he was entitled to a free hand in treating his patients in the hospital without any single restriction whatsoever. He argued that the license to practice medicine issued by the State Board of Medical Examiners imposed no restrictions upon his practice.

* Prepared at the request of The Medical Association of Georgia. Mr. Moore is a member of the firm of Alston, Miller & Gaines, General Counsel to The Medical Association of Georgia.

The hospital defendant maintained that the physician licensed to practice medicine did not give him a license to practice all kinds of procedures in the hospital and that the hospital, acting through its medical staff and governing board, could impose reasonable restrictions upon the nature and extent of practice of staff members provided such restrictions were uniformly applied and were based upon a fair analysis of the education and training of the particular staff member.

Supreme Court Decision

The Supreme Court of Georgia unanimously affirmed the decision of the trial court in favor of the hospital and the hospital authority.

The decision by the Supreme Court of Georgia re-emphasizes the position long taken by the courts but sometimes not entirely understood by individual practitioners. So long as a hospital has reasonable regulations applied uniformly to all applicants, it has every right to impose reasonable restrictions on the nature and extent of practice in the hospital by staff members even though such staff members are fully licensed by State law to practice all kinds of medicine and surgery. Although the statutory language concerning the grant of the license to practice medicine is unqualified, it should be recognized that State licensure establishes certain minimum criteria of competence and does not seek to regulate the gradations of practice and specialization of practice. This function remains the responsibility of hospitals acting through their medical staffs and through their final legal authority, the governing boards.

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The case commented upon in the above article is Yeargin v. Hamilton Memorial Hospital, Supreme Court of Georgia No. 25421, October 1, 1969.

HEALTH BOARD RESTORES MENTAL HOSPITAL FUNDS

The State Board of Health, which at its September meeting struck \$16.5 million from Georgia's public health budget requests for fiscal 1971, partially reversed its action in October and restored \$4.3 million of the amount cut.

Funds totalling \$1,430,000 were restored for con-

struction of new regional mental hospitals in Columbus and Rome. Another \$2 million was re-inserted in the request for the state's Medicaid program, "principally for nursing homes."

The Board action, on a vote of 10 to four, followed long discussion.

I enjoy convalescence. It is the part that makes the illness worth while.

—George Bernard Shaw



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SOCIETIES

The Georgia State Obstetrical and Gynecological Society is sponsoring a series of 12 half-hour films on pregnancy, prenatal care, delivery and maternal and child health services, to be aired on Channel 8, Oct. 2 through Dec. 18.

Clay County was honored in September by the Georgia Department of Public Health as the number one county in the State in the utilization of health department-sponsored family planning services.

PERSONALS

First District

Carson B. Burgstiner has been elected president of the Savannah Symphony Society, Inc.

Second District

Charles Hollis was the principal speaker at the

September meeting of the Camilla Rotary Club. He spoke on heart disease and its prevention.

Fourth District

Paul E. Fitzpatrick of Forest Park is physician for Clayton Junior College.

Sixth District

Thomas W. Gilmore, Jr., has rejoined William Rawlings and Dean L. Holmes for the practice of internal medicine.

Seventh District

Ted Cash has moved his practice to Kitchens Clinicians Hospital in Lafayette, from Tallapoosa.

Phillip Z. Israel spoke on the early detection of cancer at the August meeting of the Marietta Lions Club.

Eighth District

Vilda Shuman has been named a Head Start consultant by the American Academy of Pediatrics.

Ninth District

John E. Fowler has been elected to active membership in the American Academy of General Practice.

Thomas Lumsden presided at the Rural Health Conference held Sept. 10-11 in Macon.

DEATHS

Warren Speer Dorough

Warren Speer Dorough, former chief of staff and surgery at Georgia Baptist Hospital, died September 25 in Atlanta.

He had also served as director of the intern and residency program at Grady Memorial Hospital from 1930 to 1942 and as director of medical aid at the State Health Department.

Dr. Dorough was graduated from Emory University and Emory's School of Medicine, where he taught from 1933 to 1966. While serving in the U.S. Navy he was chief of surgery at the Marine Corps Recruit Depot at Parris Island, S.C. and the Naval base hospital at Honolulu, Hawaii.

Dr. Dorough was a member of the Fulton County Medical Society, the Medical Association of Georgia, the Southeastern Surgical Society and the Atlanta Athletic Club.

Dr. Dorough is survived by his widow, a son and two brothers.

THE MONTH IN WASHINGTON

Health, Education and Welfare Secretary Robert Finch has asked a special Task Force on medicaid to examine and make recommendations on proposals for a sweeping national health program.

The Task Force, headed by Walter J. McNerney, president of the Blue Cross Association, is scheduled to issue a report about the first of the year.

After referring to a proposal for universal health insurance endorsed by many governors at the National Governor's Conference, Finch told McNerney in a letter:

"I would like specifically to request that the Task Force consider, along with its other deliberations on medicaid and related programs, what directions and initiatives you feel the HEW Department should pursue in this area."

Extension of Medicare

According to McNerney, one phase of the study would include the extension of medicare to persons of all ages, roughly the national compulsory health plan backed by Walter Reuther of the United Auto Workers and his committee of 100 for National Health Insurance.

McNerney, however, also said that all types of mass plans would be studied, including the health insurance tax credit proposal endorsed by the American Medical Association.

The rapidly rising costs of medicare and medicaid have brought the issue to the forefront. The Adminis-

tration said older people who enter the hospital after January 1 will have to pay for an additional \$8 of their hospital bills due to the higher costs. The increase is required by law.

The benefit cutback results from an adjustment of the portion of the hospital bill for which a medicare beneficiary is responsible if these costs have risen substantially.

Federal Health Effort

After a two-year study, Sen. Abraham Ribicoff (D., Conn.), former HEW Secretary, said he's reached the conclusion the federal health effort "is a planless conglomeration of programs administered by more than a score of agencies and departments."

Federal health spending "instead of supporting programs to provide for the health of the people . . . is maintaining a cumbersome, disjointed bureaucracy that even key government officials have difficulty managing," he told the Senate.

"Instead of eliminating problems (they) may be adding to factors such as rising costs, limited access to care and the fragmented organization of health services."

"There are so many programs administered in such bureaucratic confusion that no one—not the HEW Department, not the Bureau of the Budget nor any private organization was able to tell the subcommittee even how many programs there are."

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Treatment of Drug Dependents

The American Medical Association told Congress drug dependent persons should be treated as patients rather than criminals.

In testimony before the Senate Juvenile Delinquency Subcommittee, Henry Brill, M.D., chairman of the AMA's Committee on Alcoholism and Drug Dependence, said physicians are concerned over legislation before the Subcommittee proposing harsher penalties for persons unlawfully possessing drugs for their personal use.

"Mere possession for personal use of depressant and stimulant drugs having a legitimate medical usage should not constitute an offense," Dr. Brill said. "The degree of social hazard and the reasons for having the drug should be taken into account."

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ATLANTA, GA. 30303 Mrs. J. R. Dollar

"With respect to the entire section on offenses and penalties, we propose an amendment to direct courts to appoint a panel of medical experts in each case where a drug abuser is brought to trial on a charge of illegal possession and where, in the court's opinion, medical treatment may be indicated. The panel would make a determination as to whether the defendant has a medical problem associated with his abuse of drugs—a physical or psychological disability or drug dependence.

Recommendation for Treatment

"If medical treatment is indicated, the panel would recommend to the court the type of treatment needed—that is, general medical or psychiatric care; in-patient hospitalization or clinical treatment; group therapy; half-way house etc. If medical treatment is not indi-

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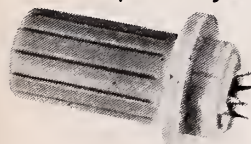
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WASHINGTON / Continued

cated, or if measures in addition to medical treatment are needed, the court would then consider the non-medical handling of the case."

Under the proposed AMA changes, the HEW Department, rather than the Justice Department, would control the official classification of drugs, and the research and public education programs in the field. Control provisions would focus on manufacturers and distributors, rather than on physicians.

"We recommend that as a matter of public policy Congress explicitly charge the HEW Department with the major responsibility for research on all aspects of drug abuse and dependence other than enforcement," said Dr. Brill.

The AMA supports provisions in the legislation

"which would allow researchers to withhold names of subjects, and to handle controlled drugs without prosecution, especially on state and local levels, has served to hamper needed research in the past."

Require Foreign Internship

The American Medical Association supported legislation to require foreign medical graduates trained in this country to spend two years of residence in their native land or land of previous residence before becoming eligible to apply for U.S. citizenship.

C. H. William Ruhe, M.D., director of the AMA's Division of Medical Education, said the measure would strengthen the Exchange Visitor Program. However, Dr. Ruhe suggested that the provision be strengthened to require that citizens of less-developed nations return to their home countries rather than their latest

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nation of residence. He cited the example of citizens of India who come to the United States from England.

"If such participants are required merely to return to England there will be no alleviation of the brain drain from India," he told the House Judiciary Subcommittee on Immigration.

Departmental Reorganization

The HEW Department's Children's Bureau was broken into separate health and welfare units.

Under the reorganization:

- Health programs administered by the Children's Bureau were transferred to the Health Services and Mental Health Administration (HSMHA) where they will form a new organizational unit. Programs included are for maternal and child health services, crippled children, maternity and infant care, and health of school and pre-school children.

- The Children's Bureau as such goes from the Social and Rehabilitation Service to the office of the HEW Secretary, where it becomes part of the new Office of Child Development. The Bureau will main-

tain its role of leadership and coordination of child and parent programs throughout the Department. It will also continue to investigate and report on all matters pertaining to the welfare of children.

- Community services administration is established in the Social and Rehabilitation Service to consolidate the administration of social service programs for children and adults. These include programs located previously in the Children's Bureau and in other agencies of the Social and Rehabilitation Service.

"I expect the Office of Child Development and the Children's Bureau to be vigorous advocates of the interests of children," HEW Secretary Robert Finch said. "They will work directly with public and private agencies to stimulate improvements in the availability and quality of services to children and parents, and to work with all agencies of HEW."

Secretary Finch said that maternal and child health programs will be strengthened by their placement in HSMHA. "All of the health programs administered by HSMHA should benefit from this new and closer relationship," the Secretary said.

A story circulated about a man who had decided gradually to give up everything that scientists have linked to cancer.

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—Anonymous

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Cover

Cover designed by Marie Seaman.

The consequences of circulatory alterations associated with vascular surgery are discussed.

Physiological Effect of Cardiovascular Surgery

THOMAS J. YEH, M.D.,* *Savannah*

SURGERY ON ANY PORTION of the cardiovascular system necessarily pre-supposes temporary interruption or reduction of circulation to an organ, a region or the whole body, depending upon the portion of the circulatory system which is being operated upon. In some types of surgery, the circulation will have to be maintained by artificial means with the use of extra-corporeal circuit. This, in turn, produces a set of problems and complications of its own.

When a certain portion of the body is deprived of its circulation, the following events invariably take place. These are: (1) Hypoxia, (2) Hypercarbia, and (3) Metabolic acidosis. Of these, the most damaging is cellular hypoxia. Various tissues and organ systems have different tolerance limits to hypoxia beyond which cellular death takes place and damage becomes irreversible. It is important that the circulatory arrest stay well within the limit of this hypoxic tolerance. Generally, the more specialized the organ the shorter the circulatory occlusion time which can be tolerated. Whereas one may safely occlude the femoral artery for two to three hours without permanent damage, the circulatory occlusion tolerance for the kidneys is in the range of one hour. The spinal cord can tolerate ischemia for approximately eight to 12 minutes, and the brain can tolerate only three to four minutes. This three to four minute limit for the brain is what dictates the permissible total circulatory arrest, be it intentional as in the correction of pulmonary stenosis under inflow occlusion, or unintentional as in the case of cardiac arrest due to hypoxia. If effective circulation is not re-established in

three to four minutes, likelihood of permanent brain damage invariably ensues.

Prolong Tolerance Limit

There are means available to prolong the tolerance limit of circulatory arrest. These means are of two forms: (1) Reduction of the rate of metabolism, and (2) increase of the amount of oxygen in the tissues and blood prior to the circulatory arrest.

(1) *Hypothermia*—By reducing the temperature of the tissue, the rate of metabolic process can be slowed down. For reduction of each 10 degrees centigrade, the metabolic process is reduced to approximately one-half, and therefore the circulatory occlusion time doubled. This principle applies within reason for both whole body hypothermia and local hypothermia. For instance, as in the repair of atrial septal defect by inflow occlusion, circulatory arrest time can be increased six to eight minutes if the body temperature is cooled down to 28 to 30 degrees centigrade. The hypoxic tolerance time of the heart can be increased from one to two hours if local hypothermia is applied to the myocardium.

There are two main methods which are used to produce hypothermia. One is external hypothermia, which is exemplified by immersion hypothermia in which the patient or organ is put into a bath of cold water. This type of hypothermia is time-consuming and the surface and muscle mass cools much faster than the core of the body (consisting of brain, heart, kidneys, liver and other abdominal organs). The other method is internal or core hypothermia which is induced by cooling the blood which perfuses the organ or body. Hypothermia used in conjunction with extra-corporeal circulation is an example of this latter type. In this situation the hypo-

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thermia takes place quickly in the core of the body, but the muscle mass and skin lag behind in its cooling. This difference in the speed of cooling, or temperature gradient, produces undesirable features in the management of hypothermia.

Another limitation of hypothermia has to do with the depression of the action of the myocardium by hypothermia. Below 25-27 degrees centigrade the myocardium cannot maintain effective circulation, and some type of circulatory assistance will become necessary. Because of these limitations and difficulties hypothermia has found decreasing applications in clinical surgery and in many Centers this method is now seldom used except under very specific circumstances.

(2) *Metabolic Inhibitor*—Experimental work has been done using chemical substance such as magnesium sulphate to inhibit the metabolic process. This work is done mainly in conjunction with organ preservation for transplantation, and it has not found clinical application as yet.

(3) *Hyperbaricity*—By increasing the atmospheric pressure one can increase the dissolved oxygen in the blood and in the tissue. Combined with hypothermia, which increases the solubility of the oxygen, a tremendous quantity of oxygen can be made to dissolve in the blood and tissue fluid. By this means, circulatory occlusion time can be increased. Again, the procedure is quite cumbersome requiring expensive and complicated equipment fraught with many hazards both to the operator and to the patient. The initial enthusiasm for hyperbaric oxygenation has now died down and it is safe to say this is not going to find wide clinical application in cardiovascular surgery.

Procedures Within Limits

For most peripheral vascular surgery the procedures can be done within the allowable limit of ischemic tolerance. This is true in cases of abdominal aorta, iliofemoral arteries, renal arteries, and in most cases, carotid arteries where the collateral circulation is well established. In some cases of carotid artery surgery, when collateral circulation is inadequate, internal shunt can be used to assure continued, even though reduced blood flow, to the part of the brain to protect it from irreparable damage.

In case of surgery involving the heart itself, or great vessels such as ascending aorta or the main pulmonary artery, it becomes mandatory that some means of supporting circulation be provided while the intracardiac repair is undertaken in an unhur-

ried manner. The equipment used for extra-corporeal circulation is usually termed very appropriately as "Heart and Lung Machine," since it takes over the function of the heart and lung during the period of intracardiac surgery.

It goes without saying that recent advances in intracardiac surgery, including heart transplantation, would not have been possible without availability of safe and dependable equipment for extra-corporeal oxygenation and circulation of the blood. There are many problems inherent to the use of extra-corporeal circulation as with any complicated equipment. Several major types of oxygenators are available. These are the screen, disk, bubble, and membrane oxygenators. Each has its advantages and disadvantages, but all have been used successfully and very satisfactorily in clinical cardiac surgery.

The other integral part of heart and lung machine is the pump which returns the oxygenated blood to the patient. This portion of the equipment is relatively simple. Like any pump, the heart and lung machine has to be primed with blood or blood substitute. It is no longer necessary, or even desirable to prime the pump with a large quantity of fresh heparinized blood. Most Centers now use blood substitutes such as Ringer's Lactate or Glucose in water with pH and electrolytes adjusted to near physiological range. Of the prime importance is the flow rate of extra-corporeal circulation. Since the function of the heart and lung machine is to maintain the circulation while the heart is being repaired, it follows that the more physiological blood flow rate can be delivered to the patient, the better. This is particularly important when the patient has to be maintained on extra-corporeal circulation for more than an hour or two, during which more difficult repair is being undertaken. One should strive to deliver the flow which is nearer the normal resting cardiac output. In normal sized adults, four to five liters per minute of flow is necessary. For a shorter perfusion, however, a reduced flow can be tolerated without serious consequences. As mentioned previously, hypothermia is no longer used very much and one tries to maintain nearly normal temperature in the extra-corporeal circuit. As to the duration of perfusion, with an adequate equipment and perfusion rate, a patient can be maintained on extra-corporeal circulation for several hours with expectation of survival. It is more important to do an adequate intracardiac repair than to minimize the duration of extra-corporeal circulation. A patient will have a much better chance of survival and improvement if the cardiac defect is repaired properly even though it takes longer on the pump oxygenator, than if he had a hasty, inadequate re-

pair during the short run of extra-corporeal circulation.

Mechanical Difficulties Encountered During the Extra-Corporeal Circulation

There are several difficulties which may be encountered in any extra-corporeal circulation.

Inadequate Flow—If the venous return is not adequate from the patient to the oxygenator, the reservoir level will be reduced and one will not be able to deliver adequate flow back to the patient. Sub-optimum flow, if prolonged, can lead to very serious consequences. The poor results from the early days of open heart surgery are mostly due to sub-optimum blood flow.

Inadequate Oxygenation—If one is dealing with a large patient, the oxygenation capacity of the oxygenator may be exceeded. This will lead to hypo-oxygenation of the arterial blood which is being returned to the patient. Some degree of inadequate oxygenation is surprisingly well tolerated as long as the flow is adequate because the tissue can extract oxygen even from the blood which is not fully saturated.

Blood Trauma—Regardless of the type of oxygenator one uses, there is certain amount of trauma which is inflicted upon the formed elements and proteins of the blood. The prime source of blood trauma is the suction unit which removes the blood from the field to return this to the oxygenator. The second major source of the trauma is in the oxygenator itself, and some types are worse than others. The pump itself is a relatively atraumatic part of the circuit. The red cell destruction is manifested by hemolysis and appearance of hemoglobin in the urine. The platelets are depleted. A certain degree of defibrination may take place and this will result in difficulty with hemostasis. The blood protein has been found to become denatured, also.

Clinical Complication of Extra-Corporeal Circulation

Manifestation of complications of extra-corporeal circulation are multiple and involve virtually all organ systems. The knowledge gained in observing and managing the complication of extra-corporeal circulation has been applied widely in the management of traumatic or septic shock, other types of post-operative situations and other serious respiratory and metabolic derangements. The methods of monitoring the various parameters, which were initially applied in open heart surgery, are now being used in a host of other clinical conditions.

Low Cardiac Output Syndrome—One of the most serious complications seen in the early post-opera-

tive period is so-called low cardiac output syndrome. The clinical picture is manifested by peripheral vascular constriction, hypotension, diminished peripheral pulse, restlessness, cold extremities, cyanosis of the nail beds and mucous membrane in spite of oxygen administration. The picture is very similar to that of hypovolemic shock. Prolonged myocardial ischemia during surgery and improper repair of cardiac defect probably contribute to the occurrence of low cardiac output syndrome. Metabolic acidosis, which is a manifestation of low cardiac output, tends to aggravate the condition by impairing the myocardial contractility. The management of this condition consists of adequate fluid replacement as guided by venous pressure, blood pressure and urinary output, correction of metabolic acidosis and correction of hypoventilation if these exist. Tracheostomy with controlled respiration sometimes is invaluable in the management of low cardiac output syndrome. This spares the cardiac output which is expended in maintaining the work of respiration. The work of respiration may be increased considerably in these patients since they have had thoracotomy, and there are frequently pulmonary parenchymal changes due either to underlying lung disease or from cardio-pulmonary bypass.

Perfusion Lung Syndrome—Clinically and pathologically the pump lung syndrome resembles respiratory distress syndrome of newborn babies. It usually manifests itself within the first day or two after surgery by the onset of dyspnea, cyanosis and hypoventilation. The alveolar surfactant depletion has been incriminated as the cause of the pump lung syndrome, but this point is far from being settled. Chemically it is characterized by hypoxia and/or hypercarbia, with or without metabolic acidosis. In severe cases autopsy examination will show congestive atelectasis and proteinaceous material in the airway and alveolar spaces. There is no specific management for this aside from establishment of the airway and assisted or controlled respiration.

Metabolic Acidosis—Anaerobic metabolism with accumulation of lactic, pyruvic and other fixed acids is frequently present after prolonged cardio-pulmonary by-pass, particularly if inadequate flow is used. If the post-operative output is adequate, the metabolic acidosis rapidly disappears. However, if the cardiac output is marginal, acidosis will persist. Arterial blood gas analysis is mandatory in the post-operative open heart cases to detect metabolic acidosis. This is manifested by negative base excess values. The relationship between low cardiac output syndrome and metabolic acidosis has been mentioned. Metabolic acidosis is corrected by the ad-

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ministration of intravenous sodium bicarbonate at a calculated value based on the patient's body weight and the base deficit, and by removing the causative factors.

Acute Renal Failure—Acute renal failure following open heart surgery is a largely preventable condition. It occurs after prolonged cardio-pulmonary by-pass, particularly with inadequate flow, and when the hemolysis is excessive. Development of the acidosis has been incriminated as a contributing factor to renal failure also. Clinically, renal failure is manifested by decreasing urine output during the first few post-operative days, increasing serum potassium and blood urea nitrogen and development of metabolic acidosis. During the very early stage this condition is reversible by correction of the underlying cause such as low cardiac output, metabolic acidosis, hypotension, or hypovolemic shock. Mannitol infusion may be tried both as a diagnostic and therapeutic measure. Once renal failure is established, however, mannitol will be useless and management from then on will be by the conventional methods, namely, accurate fluid replacement and the electrolyte management, control of hyperkalemia by either exchange resin or peritoneal dialysis and occasionally artificial renal dialysis. Recovery is the rule and it may take two to three weeks.

Cerebral Damage—One of the most distressing complications of open heart surgery is brain damage. This is particularly so when everything else has gone very well, but the patient will not wake up after termination of anesthesia. There are at least two different mechanisms in the brain damage following open heart surgery. One is air embolism. This is a constant danger when the left side of the heart has to be opened. It occurs during the cardiopulmonary by-pass when the air is trapped in the left side of the heart, or when the level of the reservoir in the pump oxygenator gets too low and some air is allowed to get in the arterial line. The symptoms range from minor to profound brain damage according to the amount of air which reaches the brain. A completely unconscious patient may recover after several days. Usually, however, if the patient has shown no recovery of cerebral function after one or two weeks, the eventual prognosis is very poor.

The other mechanism of brain damage is due to decreased cerebral blood flow during or after cardiopulmonary by-pass. It frequently occurs when there was a period of arrhythmia or cardiac arrest. The management of the cerebral damage is mainly by supportive measures consisting of maintaining

the circulation and adequate oxygenation, mild degree of hypothermia and avoidance of fluid overload.

By and large, the complications of cardiovascular surgery can be prevented or managed in its early phase. With increasing experience, the complication rate has been reduced gradually and steadily. For instance, among forty or so open heart cases we have done in Savannah, there have been no cases of renal failure, air embolism, or pump lung syndrome.

Summary

Physiological derangements associated with circulatory occlusion and use of cardiopulmonary by-pass were reviewed. Etiologic factors, prevention and management of clinical complications of cardiovascular surgery, such as low cardiac output syndrome, perfusion lung syndrome, metabolic acidosis, acute renal failure and brain damage were discussed.

Memorial Medical Center

APPALACHIAN REGIONAL COMMISSION RESOLUTION NUMBER 203

A resolution commending the Student American Medical Association and the National Student Nurses Association

The Commission commends the Student American Medical Association, the National Student Nurses Association, the individual medical and nursing students, the hosting physicians, nurses, and agencies who participated in, and contributed to the success of the summer intern program, sponsored by the Commission, which placed 88 medical students and 20 nursing students in various areas throughout the Appalachian Region to acquaint them with the challenges and opportunities in rural health practice.

The Commission is deeply concerned that many areas of Appalachia continue to be plagued by high levels of infant mortality, chronic disease and environmental health problems and that these problems are compounded by an increasingly acute shortage of physicians, nurses and other health personnel in the Region.

The summer health program managed by the Student American Medical Association, in cooperation with the National Student Nurses Association, eloquently demonstrated the high ideals, vigor and commitment of many of today's young people in the health professions. Their services, this summer, contributed much to improve the quality of life in the Region. From their experiences, much has been learned. The message that they will carry to medical and nursing schools all over the country represents an important source of hope for better health in the Region. The Commission is deeply appreciative of their continued zeal.

Medical College of Georgia

Department of Medicine

Grand Rounds

THYROTOXICOSIS AND THYROTOXIC HEART DISEASE

D. B. PRIDGEN, M.D.,* T. E. TEMPLE, JR., M.D.,†
and PAUL E. CUNDEY, JR., M.D.,‡ *Augusta*

A 35-YEAR-OLD NEGRO MALE was admitted to the Medical College of Georgia-Talmadge Memorial Hospital in mid-April, 1969, for evaluation and treatment of hypertension and refractory heart failure. High blood pressure was first recognized two years earlier and treatment with a variety of medications produced a modest therapeutic response. Four months before admission he experienced severe stabbing mid-chest pain associated with diaphoresis and intense throbbing headaches, relieved by aspirin. He did not seek medical care and subsequently shortness of breath appeared. Two weeks of self-imposed bed rest resulted in improvement in his symptoms. Three months before admission pedal edema and nocturia appeared and his shortness of breath became more severe, forcing him to see his physician. Despite digitalis his symptoms persisted and symptomatic tachycardia developed. Despite peripheral edema he had recognized a 25-pound weight loss. Nervousness and insomnia had been present throughout this illness and were accompanied by striking hyperphagia.

His past history revealed recurrent episodes of tonsillitis with associated arthralgia and fever at age 14. There was a history of large quantities of beer consumption.

His father died at age 40 of high blood pressure and heart failure. His mother, age 57, has high blood pressure. Two siblings are living and well. No family history of goiter or hyperthyroidism was obtained.

Admission physical examination revealed a tall, slender, well-developed, hyperactive Negro male

with evident weight loss. His blood pressure was 170/105, pulse was 110 and regular, respirations were 22, and temperature was 37°C. (96.6°F.) The skin was warm, moist and smooth. His eyes were normal including intrinsic and extrinsic muscles, conjunctivae and fundi. No lid lag was demonstrable. The ears, nose and throat were normal. Severe dental caries was noted. The tongue exhibited a rapid, fine tremor on extension. A nontender, diffusely enlarged goiter, weighing approximately 60 grams, was palpable. No bruit was heard. Both carotid pulses were palpable, bounding and rapid. No jugular venous distention was noted. No cervical or other lymphadenopathy was found. The chest revealed mild, tender gynecomastia on the right. The lungs were clear. The heart was enlarged, the point of maximal impulse being in the sixth left intercostal space in the anterior axillary line. A rapid rate of 110 per minute with a regular rhythm was found. All of the heart sounds were accentuated. The pulmonic component of the second heart sound was equal in intensity to the aortic component. A grade 2/6 systolic ejection murmur was heard in the pulmonic area but a Lerman-Means scratch was not noted. The abdomen was flat with no palpable masses or organs. Bowel sounds were normal. Genital and rectal examinations were normal. The extremities were symmetrical and exhibited a 1+ pitting pretibial edema. All pulses were palpable, rapid and bounding. A rapid, fine tremor of the hands and extended fingers was apparent. Moderate weakness of the proximal muscles of the arm and legs was found. Neurological examination revealed normal sensory findings. The cranial nerves were normal. The reflexes were active and relaxation rates were rapid.

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Laboratory Data

Hemoglobin was 11 grams, hematocrit 34 per cent, WBC 6800/mm³ with normal differential count but some toxic granulation of the polymorphonuclear leukocytes; urinalysis normal; VDRL non-reactive; serum cholesterol 58 per cent per 100 ml.; creatine phosphokinase 5.0 units per ml. (normal 0-35 units); serum calcium, phosphorus, uric acid, creatinine and electrolytes were normal. The total serum proteins were 8.0 grams per 100 ml. with 3.4 grams albumin. The oral glucose tolerance test revealed: fasting 95, 30 minute, 235; 60 minute, 195; 120 minute, 143; 180 minute, 80, and 240 minute 103 mg./100 ml. of blood glucose. PBI was 17.5 µg. per 100 ml. with a thyroxine of 14.6 µg. (normal 2.4-6.2 µg./100 ml.). Iodine¹³¹ uptake was 71 per cent at 6 hours and 77 per cent at 24 hours (normal less than 15 per cent at 6 hours and less than 40 per cent at 24 hours). Electrocardiograms showed sinus tachycardia, left ventricular enlargement, T wave inversion in lateral precordial leads and digitalis effect, but no evidence of a previous myocardial infarction.

Chest roentgenogram revealed clear lungs and cardiomegaly.

Hospital Course: A diagnosis of hyperthyroidism was made and propylthiouracil 900 mg. daily was administered with digitalis and a diuretic. Shortly after starting the antithyroid medication he was discharged. In the ensuing two months he failed to take his medications, his symptoms continued, and he was readmitted.

Second Admission

The physical findings were unchanged except for the thyroid gland which was now approximately four times enlarged, about 80 grams. He had no detectable edema.

Laboratory Data: The majority of the data was unchanged from the first admission. PBI had increased to 19.2 µg. and serum cholesterol to 111 mg. per 100 ml. Chest roentgenogram and electrocardiogram were unchanged.

Hospital Course: Propylthiouracil was restarted and the dosage increased to 300 mg. every six hours. After four weeks of *in hospital* treatment a euthyroid state has been achieved. He has gained 10 pounds in weight and lost all evidence of cardiac insufficiency. Lugol's solution 10 drops orally three times daily has been initiated and a subtotal thyroidectomy is planned.

DR. T. E. TEMPLE, JR.: I shall discuss some of the features of Graves' disease seen in this man; Dr. Cundey will then talk about the cardiovascular aspects of Graves' disease. First, are there any questions about the case history?

DR. PAUL WEBSTER: Did the patient exhibit any change in skin pigmentation?

DR. PRIDGEN: No.

DR. WEBSTER: Were liver function studies obtained?

DR. PRIDGEN: Yes. SGOT, SGPT and LDH were performed during the first admission and were normal. They have been repeated during this admission.

DR. TEMPLE: The point which Dr. Webster alludes to in his first question is the finding of vitiligo in a small percentage of patients with Graves' disease. I will defer comment on the hepatic function derangements seen in this order.

This man presents a classic example of Graves' disease. Of the four well-established features of this illness, diffuse thyromegaly, exophthalmos, thyroid dermopathy (pretibial myxedema), and the presence of Long Acting Thyroid Stimulator (LATS) in the serum, we can be certain of only one—the diffuse goiter. We have not attempted to detect LATS. Another classic, though uncommon, feature of Graves' disease is a specific type of clubbing, the so-called thyroid acropachy. This occurs in only 5 per cent or so of most series and was not found in our patient. Even though he exhibited only a diffuse goiter, his symptoms and related physical findings should make one consider the diagnosis, and strong confirmation was obtained from the laboratory.

What the incidence of this disease is in our area, I don't know, but geographic variability in thyroid disorders is well known.^{1, 2} It is a common disorder based on the admissions to the Talmadge Hospital. Of course in addition to prevalence rates, it must be recalled that statistics from any referral center may be biased by the indications for referral used by the multiple physicians who send patients there. The incidence of the disorder could be determined by careful epidemiologic surveys, but I am unaware of a survey for Graves' disease in Georgia in recent years.

The diagnosis of hyperthyroidism may be easy or hard depending upon the manifestations in a given patient. In 1960, Wayne described a Clinical Diagnostic Index for Thyroid Disorders.³ This has been most useful in patients with small goiters and few of the peripheral features of the disease; most commonly these are older patients whose major com-

plaints are cardiovascular symptoms. This man was not a problem. He fits the Diagnostic Index quite closely.

Dyspnea a Major Symptom

One of his major symptoms was dyspnea. This could have resulted from heart failure, but his chest examination and x-ray revealed no congestive changes. Stein et al.⁴ and Massey et al.⁵ have studied the changes in pulmonary function which occur with hyperthyroidism. Their reports indicate that dyspnea is a common complaint in hyperthyroid patients in the absence of heart failure. Though vital capacity (VC) was not decreased in all of their patients, the VC reached predicted normal or higher levels in most patients restudied after control of the hypermetabolism. Lung compliance was diminished in all patients and increased following treatment. Maximal inspiratory and expiratory pressures were also decreased in the untreated state. Diffusing capacity, pulmonary capillary blood volume, and membrane diffusion were not altered by the hyperthyroid state. Intercostal and extrinsic respiratory myopathy may cause dyspnea but dyspnea occurs in the absence of this abnormality.⁶

When I first examined this man, he had been taking propylthiouracil for several days, but still exhibited tachycardia and prominent proximal muscle weakness. Myopathy is probably much more common in hyperthyroidism than is generally appreciated. Failure to recognize myopathy results usually from failure to adequately question patients about muscle symptoms and failure to evaluate muscle strength. The next Grand Rounds will cover this problem also.

A diagnosis of "refractory heart failure" at any age should stimulate consideration of possible underlying Graves' disease. Inadequate response to digitalis is a consistent feature of hyperthyroidism. The association of atrial fibrillation with hyperthyroidism is commonly recognized, and is present in about 10-20 per cent of most series.^{6, 7} Paroxysms of atrial tachycardia (PAT) have been considered by some observers to be a typical feature of the disorder. In actuality, this may not be true though our patient did have intermittent episodes of PAT. Vazifdar and Levine analyzed 200 cases of hyperthyroidism and found no cases with PAT.⁷ They did find 34 patients with persistent atrial fibrillation, 11 cases of paroxysmal atrial fibrillation and six with atrial flutter. What do these episodes mean in our patient? Perhaps Dr. Cundey will talk about this.

Gynecomastia

Another feature which this patient demonstrated is gynecomastia. About 10 per cent of male pa-

tients with Graves' disease develop gynecomastia.⁶ Though digitalis might also be incriminated as the cause of gynecomastia, his breast enlargement appeared before digitalis was administered. Thus, this drug could have contributed to but was not the primary cause of the glandular breast development. After control of the hyperthyroidism, gynecomastia disappears in a variable period of time.

The mild degree of anemia present in our patient is similar to that described by Rivlin and Wagner⁸ in a small group of hyperthyroid patients. Ferromagnetic studies have not been performed in E. M. but in the study cited⁸ there is decreased utilization of iron in some patients with hyperthyroidism. The cause of normal or increased iron turnover in some patients and decreased turnover in others is not clear. DeGroot has recently re-emphasized the correlation of thyroid diseases with chronic gastritis and the development of Vitamin B₁₂ malabsorption.⁹ E. M. exhibited no features of pernicious anemia, but this association had been reported for many years before the delineation of autoimmune phenomena in both thyroid and gastric dysfunction.

Some discussion of the metabolic basis of Graves' disease is in order. I would like to equate the pathogenesis of Graves' disease with the pathogenesis of Cushing's disease but it cannot be done. While in Cushing's disease the problem is an abnormality in adrenocorticotrophic hormone secretion from the pituitary, in Graves' disease thyroid stimulating hormone is not involved. On the other hand, identification of a 7S gamma globulin fraction with the capacity to stimulate growth, hormonal synthesis, and hormone discharge from the thyroid gland has been clearly linked with Graves' disease.¹⁰ This substance, LATS, can be found in the sera of approximately 50 per cent of patients with the disorder.¹¹ Why can't it be found in all of the patients? No one knows the reason but the commonly accepted explanation is the low sensitivity of the LATS bioassay. Solomon and his colleagues¹¹ have reviewed this problem as part of a general discussion of hyperthyroidism and I would recommend their paper to anyone interested in a careful survey of the subject.

Treatment for Hyperthyroidism

What form of treatment is best for hyperthyroidism and specifically for this patient? At the time we first examined him, oral antithyroid medication to be followed by subtotal thyroidectomy had been planned. This is a perfectly adequate mode of therapy. In the selection of therapy one must weigh multiple factors. These include age, reproductive state, coexistent illnesses, severity of Graves' dis-

ease, and operative risk but the single most important factor is reliability of the patient in following instructions and taking medication.

Surgery preceded by control of the hyperthyroidism with oral antithyroid agents remains a commonly used approach. Caswell et al.¹² treated 208 patients with hyperthyroidism by subtotal thyroidectomy. In this group were 149 patients with Graves' disease of which 143 were cured. Six patients had recurrence of hyperthyroidism. Their incidence of postoperative myxedema was 4 per cent but this figure is based upon the entire series of 208 patients. From the available data the exact incidence of postoperative myxedema in Graves' disease in this series cannot be determined. In addition, the incidence of hypothyroidism at 5, 10 or 15 years after surgery is not specified. Green and Wilson¹³ found a 6 per cent incidence of hypothyroidism 10 years after subtotal thyroidectomy. Seventy-eight per cent of their patients were euthyroid one year after surgery. Neither study^{12, 13} had any permanent hypoparathyroidism but Green and Wilson¹³ reported a 5 per cent incidence of recurrent laryngeal nerve palsy. Hershman¹⁴ in a survey of eight surgical clinics found permanent hypothyroidism in 4 per cent to 29 per cent of patients following subtotal thyroidectomy. Recurrence of hyperthyroidism varied from less than 1 per cent to 17 per cent and permanent hypoparathyroidism from 0 to 3.6 per cent.

Radioiodine (131-I) has been extensively used for the past two decades. The ease of treatment has recommended it to many people. However, a rising incidence of post therapy hypothyroidism has dampened some of the initial fervor for this agent.¹⁵ Nevertheless, radioiodine remains an effective agent for treatment of Graves' disease since 70 per cent to 80 per cent of patients in most series have been "cured" with a single dose of 131-I.¹²⁻¹⁴ Pennington and Martin¹⁶ have found that administration of oral antithyroid agents beginning a few days after 131-I decreased the incidence of hypothyroidism to about 21 per cent at 15 years. Unfortunately, this maneuver may also decrease the cure rate with a single dose of isotope. The problem of when to use 131-I based upon age has been lucidly discussed by Stanbury.¹⁷ As with any therapy, one must use cautious judgment in selection of patients for 131-I treatment. While I adhere to the general rule of not using it in patients below ages 35-40, the situation with any given patient may suggest its usefulness. For instance, I have given 131-I to an 18-year-old girl with Graves' disease and lupus erythematosus

in exacerbation; to a 23-year-old woman with moderately severe infectious hepatitis; and to a 22-year-old man with severe Graves' disease which was not controlled by three years of propylthiouracil, followed by a near total thyroidectomy.

Oral Treatment

Astwood has been the most forceful proponent of long term oral antithyroid treatment. A review of his experience and that from other groups¹⁸ revealed a permanent cure in 44-72 per cent of patients so treated. The major advantage to this therapeutic program is that one has not committed the patient to irrevocable therapy. A significant disadvantage may be failure of the patient to take the medication as occurred in the patient presented today. It has been my practice to utilize oral agents whenever possible but 131-I or surgery has been recommended for specific patients without hesitation.

DR. PAUL CUNDEY: Patients with hyperthyroidism frequently develop cardiac manifestations of their disease. These manifestations consist of tachycardia, peripheral vasodilatation, systolic hypertension and increased cardiac output. The findings, however, reflect a hypermetabolic state, and do not necessarily reflect basic changes in myocardial performance. While most investigators agree that there is an association between hyperthyroidism and altered circulatory physiology, considerable controversy persists regarding the pathophysiology of the altered circulatory dynamics. Therefore, the question, "Will hyperthyroidism of itself produce cardiac disease?" remains unanswered.

In an effort to answer this question investigators in recent years have attempted to directly evaluate the influence of thyroid hormone on the contractile properties of heart muscle and relate these to the energy stores of the myocardium. Dr. Robert A. Buccino and co-workers at the National Institutes of Health¹⁹ found that altering the level of thyroid activity significantly affected the intrinsic contractile state of cardiac muscle, and this effect was independent of norepinephrine stores and alterations in high energy phosphate stores. Thus, for the first time, a direct action of thyroid hormone on myocardial contraction was demonstrated. A second area of investigational interest has been the relationship between hyperthyroidism and increased cardiac output. While it has been known for years that thyroid hormone will increase total oxygen consumption, the increase in cardiac output in patients with thyrotoxicosis does not appear to be directly related to elevated oxygen consumption. Recent work by Theilen and Wilson²⁰ indicates that, at least in part, the increased cardiac output in thy-

rotoxicosis is secondary to peripheral vasodilatation. Peripheral vasodilatation may be necessary to provide sufficient skin blood flow to regulate body temperature.

Explains Physical Findings

These experimental findings explain some of the physical findings frequently found in thyrotoxic patients. The demonstration of increased myocardial contractility suggests that the systolic ejection click, frequently audible at the upper left sternal border could be attributed to an increased rate of ejection from the myocardial chamber. Similarly, the increased rate of ejection from the chamber probably accounts for the basal systolic murmur present in many thyrotoxic patients. The increased peripheral delivery of blood indicates increased inflow into the left ventricular chamber, which could explain the frequent presence of an S₃ and S₄ sounds. At significant degrees of tachycardia, the S₃ and S₄ may blend and produce a summation gallop.

It is important to note that studies over the last few years have failed to document a causal relationship between cardiac manifestations in thyrotoxic patients and increased sensitivity to, or increased circulating levels of, catecholamines. Failure to document this speculation places on tenuous scientific grounds the commonly employed therapeutic measure of using drugs which deplete catecholamine stores.

In summary, most patients with untreated thyrotoxicosis present with manifestations of altered circulatory dynamics. A number of the abnormal physical signs associated with these manifestations can now be rationally explained. Since cardiac manifestations are primarily those of the thyrotoxic state rather than those of an intrinsic cardiac disease state, therapy should be directed at control of the thyrotoxicosis. In certain patients, however, with an already diseased myocardium the added burden that thyrotoxicosis presents to the heart must be met with cardiac supportive therapy until the thyrotoxicosis can be brought under control. A direct causal relationship between hyperthyroidism and a cardiac disease state has not as yet been demonstrated.

DR. TEMPLE: Dr. Cundey, what is the relationship of thiamine to the cardiovascular features of Graves' disease?

DR. CUNDEY: Not only thiamine but many other vitamins may be deficient in thyrotoxicosis. Thiamine deficiency is the best documented. This observation suggests that the heart disease of thiamine deficiency may complicate any cardiac defects of thyrotoxicosis.

DR. NANCY FLOWERS: What are the current

thoughts on the use of blocking agents in treatment of Graves' disease patients?

DR. TEMPLE: Guanethidine and reserpine have been used with probable beneficial results for a number of years, mainly in severe cases of hyperthyroidism. More recently propranolol has been used. This latter drug is particularly effective in producing beta adrenergic blockade thus slowing heart rate and decreasing the hyperexcitable muscular status of the patient. I have used all three agents but only infrequently and only in severe hyperthyroidism. In hyperthyroid patients the most reliable indicator of attainment of the therapeutic goal is a careful and detailed analysis of symptoms and physical findings. Propranolol conceals most of the extra-thyroidal manifestations of hyperthyroidism and for this reason I do not use it or any adrenergic blocking drug routinely.

Medical College of Georgia

These conferences are taped weekly and are selected and edited by Joseph P. Bailey, Jr., M.D., Professor of Medicine, Medical College of Georgia. The participants are principally faculty and house staff of the Department of Medicine, or Junior Medical Students assigned to the patients. Members of other departments are so identified.

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HIGHLIGHTS OF THE MAG EXECUTIVE COMMITTEE OF COUNCIL, NOVEMBER 16, 1969

This summary is being sent to you so that MAG Officers and Councilors may be advised of the actions of the Executive Committee between meetings of Council. It covers only major actions and is not intended as a detailed report in lieu of meeting minutes.

—**Approved the policy** of allowing the purchase of a Check Writer with signature slugs, rather than requiring handwritten signatures on all checks.

—**Delayed payment of funds** to the Health Careers Council of Georgia and asked HCCG Chairman, Mr. Dan Barker, to develop a report for the MAG Council meeting in December.

—**Voted to develop a proposal** for submission to the State Board of Health on MAG provision of Medicaid Peer Review.

—**Approved the action** of the Committee on Insurance and Economics which resulted in modifications in MAG's Major Hospital and Nursing Insurance.

—**Approved Guidelines for Hospital Emergency Room Contracts** submitted by the Committee on Separate Billing and directed distribution to local medical societies and hospital Chiefs of Staff.

—**Approved for submission to Council** with Executive Committee endorsement a report on the Criteria for Conflict of Interest, drafted by the Committee on Professional Conduct and Medical Ethics.

—**Voted to oppose** the proposed Mandatory Nurse Practice Act, and to develop a letter for Council approval advising the Georgia State Nurses Association of MAG's position.

—**Reviewed a Resolution** of the Board of Medical Examiners and voted to pursue the House of Delegates passed Amendments to the Composite Board Bill (HB 655).

—**Approved the text** of Fulton County Medical Society suggestions on the licensure of clinical laboratories and laboratory personnel for submission to legislative committees.

—**Voted to seek legislation** to allow individuals to incorporate.

—**Decided to implement a previous directive** that a Hearing be called to discuss possible corporate practice implications in the Emory-Grady Contract on third-party payments.

—**Voted to direct GRMP** to hire the Coordinator at 20 per cent of time as of October 15, 1969.

—**Voted that no modifications** in the Headquarters Building be allowed except with approval of the Executive Director and appropriate approvals by the Executive Committee.

—**Noted its next meeting** for 10:00 a.m., Saturday, December 13, 1969, Atlanta American Motor Hotel.

CALL FOR SCIENTIFIC EXHIBITS

116TH ANNUAL SESSION OF THE MEDICAL ASSOCIATION OF GEORGIA

Jekyll Island, Georgia, May 7-10, 1970

For Information and Applications, Write:

John McClure, Jr., M.D., Chairman, MAG Scientific Exhibits Committee
938 Peachtree Street, N.E. • Atlanta, Georgia 30309

Once shock develops the survival of the patient is entirely dependent on the perception, attentiveness and judgment of his physician.

Treatment of Shock Following Myocardial Infarction

JAY N. COHN, M.D., *Washington, D.C.*

WHILE NEWER REFINEMENTS IN PATIENT monitoring and management have significantly reduced the mortality from acute myocardial infarction, the occurrence of shock still carries a grave prognosis.

Shock is characterized by a critical reduction in tissue perfusion. Inadequacy of blood flow impairs organ function and disrupts the integrity of normal metabolic pathways. If shock is not promptly corrected, the flow deficiency leads to organ damage, metabolic acidosis and a vicious circle resulting in progressive circulatory deterioration and death. The sooner the syndrome can be recognized the more likely is therapy to be effective. The need for prompt recognition of shock must not, however, be satisfied at the expense of "over-diagnosis." It is in this initial evaluation that the physician's perceptiveness is critical. He must be able to recognize the difference between the mildly hypotensive patient who is adequately perfusing his tissues (and needs no immediate treatment) and the patient who is in the incipient stages of shock and requires prompt therapy to restore peripheral blood flow.

In considering the diagnosis of shock, attention should be given to the following signs:

1. Skin temperature. Warm skin indicates adequate cutaneous blood flow and usually a fairly well maintained cardiac output. Cool, clammy skin indicates sympathoadrenal discharge, a sign of reflex vasoconstriction in response to a fall in cardiac output.

2. Peripheral pulses. Thready or absent brachial and radial pulses indicate either severe hypotension or more often intense vasoconstriction. In either case urgent treatment is indicated. Femoral artery pulsation will be very weak if the patient is hypotensive

but the pulsations are bounding in the presence of peripheral vasoconstriction.

3. Auscultatory blood pressure. This is not a reliable guide to intra-arterial pressure in shock. A low cuff pressure has the same significance as weak upper extremity pulses. However, an absent auscultatory pressure usually indicates inadequate blood flow and the need for treatment.

4. Mentation. If the patient is alert and responsive cerebral blood flow is probably adequate. Agitation, confusion or somnolence are signs of deficient cerebral blood flow and usually are associated with a fall in arterial pressure.

5. Urine output. Urine flow less than 20 ml/hour with a low urine sodium concentration is evidence of inadequate renal blood flow which, if not corrected, can lead to tubular necrosis.

6. Cardiac function. Persistent or recurrent chest pain or arrhythmias in the presence of other signs of hypotension may be accepted as presumptive evidence of functional impairment of coronary blood flow.

7. Acidosis. Low arterial blood pH and elevated blood lactate mean reduced tissue oxygenation. Arterial blood gas and pH studies are invaluable in the management of patients in shock.

Evidence of Shock

The presence of one or more of the above signs of inadequate tissue blood flow in a patient with an acute myocardial infarction is presumptive evidence of shock. Mild hypotension in the absence of any of these signs should not be diagnosed or treated as "shock."

When the diagnosis of shock has been made, several questions regarding the hemodynamic status of the patient should be answered before definitive treatment can be instituted:

1. Is the patient severely hypotensive? Hypotension is an immediate threat to life because of the associated impairment in cerebral and coronary blood flow. Since the cuff pressure may be low even though arterial pressure is normal, the strength of femoral arterial pulsations often is a more reliable guide to blood pressure. In some patients direct recording of arterial pressure may be necessary.

2. Is blood volume adequate? Some patients become hypovolemic in the hours following an acute myocardial infarction and the reduction in plasma volume may then become an important factor in the genesis of shock. The central venous pressure (CVP) is a vital guide to the adequacy of circulating volume and should be monitored in all patients with shock. This can be accomplished by threading a catheter through a needle in the brachial, femoral or subclavian vein and advancing it into the thorax. A low CVP (less than 6 cm H₂O with the zero level at the mid-chest) is an indication for a trial of volume expansion. In myocardial infarction the left ventricle often is in failure while CVP is normal. Therefore, volume expansion should be carried out cautiously. A rise in CVP of more than 2 cm H₂O during infusion of dextran, saline or other fluid indicates that volume has been adequately restored. If shock is not corrected by volume expansion the presence of significant left ventricular failure can be assumed.

3. Is cardiac function severely impaired? If peripheral blood flow is markedly reduced and the CVP is high, then myocardial failure is obviously an important factor in the shock. Heart rate is not a very useful index of cardiac function. Indicator dilution cardiac output data are of value in the evaluation of myocardial function in selected cases.

4. What is the status of the peripheral vessels? Is there evidence of intense sympathetic discharge? This usually is manifested by cutaneous vasoconstriction and indicates renal vasoconstriction as well. In early stages of shock peripheral constriction may support fairly normal arterial pressure despite progressive tissue hypoperfusion and lactic acidosis.

Therapy in Shock

The purpose of therapy in shock is to restore adequate organ perfusion. Effective therapy must be based not only on an understanding of the physiological disturbance in the individual patient but also on a thorough understanding of the pharmacological action of the useful drugs.

The following drugs may be valuable in certain patients with cardiogenic shock:

1. **Isoproterenol.** This is a catecholamine with pure beta adrenergic activity; that is, it stimulates the heart and dilates peripheral vessels. It is probably the agent of choice when impairment of cardiac function has led to severe reduction in cardiac output, especially when reflex vasoconstriction is present. Isoproterenol 1 or 2 mg should be diluted in 500 ml 5 per cent dextrose in water and the rate of infusion gradually increased until the signs of shock are corrected or cardiac rhythm disturbance limits further administration. In some cases the concentration of isoproterenol must be increased as much as 2 mg/100 ml to obtain a satisfactory effect. Lidocaine may be effective in controlling ventricular irritability during isoproterenol infusion. In some hypotensive patients isoproterenol will not significantly increase arterial pressure and cerebral and coronary perfusion are not improved. In this situation a vasoconstrictor-inotropic agent may be necessary.

2. **Levarterenol (Norepinephrine) or metaraminol.** These drugs have an alpha adrenergic effect (vasoconstrictor) on peripheral vessels combined with myocardial stimulating properties. Because these drugs may reduce renal and splanchnic blood flow they should be used only when isoproterenol is ineffective. The infusion rate should be the smallest amount necessary to increase systolic arterial pressure over 100 mm Hg.

3. **Digitalis.** The cardiac glycosides have inotropic effects less potent than the catecholamines. They also have vasoconstrictive properties when used intravenously. It is probably best to treat cardiogenic shock acutely with the adrenergic inotropic drugs above and to administer digitalis orally for its more sustained effect.

4. **Atropine.** If shock is associated with sinus bradycardia, 1 mg atropine intravenously may be effective in restoring heart rate and blood flow. Drugs, such as atropine and isoproterenol, which result in an increase in atrial rate must be used cautiously in the presence of atrioventricular block. Under these circumstances, an increase in atrial rate may result in a decrease in ventricular rate.

5. **Furosemide.** This potent diuretic can help establish urine output in the oliguric patient. After shock has been treated with the vaso-active compounds above, a diuretic response to intravenous infusion of 200 mg of furosemide indicates that renal perfusion is adequate. If oliguria persists, however, more aggressive attempts to improve blood flow are necessary.

6. **Sodium Bicarbonate.** If the arterial pH is less than 7.35, sodium bicarbonate should be administered in amounts adequate to restore pH to above that level. Treatment should be initiated with 40-100

mEq sodium bicarbonate and further alkali therapy based on arterial blood pH measurements.

7. Ventricular Pacing. If shock and marked bradycardia co-exist, increase in ventricular rate via catheter electrode pacing is often of great clinical benefit.

Newer pharmacological approaches such as the use of sympathetic blocking agents and other inotropic drugs, such as dopamine and glucagon, are still in the experimental stage.

Effective Shock Management

Effective management of shock requires not only initiation of the correct therapy in the correct amounts, but also close continuous monitoring of cardiovascular function. Adrenergic drugs should be weaned and discontinued as soon as possible. Blood

volume may be inadequate after cardiac function is improved, and a falling CVP may be an indication for administration of dextran, even in patients who have manifested heart failure only a few hours before. If rhythm disturbances persist electrical pacing through a transvenous pacemaker may help improve peripheral blood flow.

It is clear that intelligent use of the means currently available can be effective in salvaging many patients who would otherwise succumb to cardiogenic shock. In others, however, the impairment in cardiac performance is so severe that medical therapy is ineffective. In this selected group of patients mechanical means of temporary circulatory support may eventually become an important adjunct to management.

Georgetown University Medical Center

CALENDAR OF MEETINGS

In Georgia

- Jan. 11-14—Society of Thoracic Surgeons, Regency Hyatt House, Atlanta
- Feb. 8-10—American Society for Aesthetic Plastic Surgery, Marriott Motor Hotel, Atlanta
- March 8-10—Atlanta Graduate Medical Assembly, Marriott Motor Hotel, Atlanta
- March 15-19—Society of Toxicology, Marriott Motor Hotel, Atlanta

In the Nation

- Jan. 9-10—Council on Occupational Health, Kona Kai Club, Shelter Island, San Diego, Calif.
- Jan. 9-10—Council on Environmental and Public Health, Executive House Arizonian, Scottsdale, Ariz.
- Jan. 9-11—Residency Review Committee for Obstetrics and Gynecology, Pier 66, Ft. Lauderdale, Fla.
- Jan. 16-17—Council on Rural Health, Drake Hotel, Chicago, Ill.
- Jan. 16-17—American Society for Surgery of the Hand, Palmer House, Chicago, Ill.
- Jan. 16-17—Council on Rural Health, Drake Hotel, Chicago, Ill.
- Jan. 17-22—American Academy of Orthopedic Surgeons, Palmer House, Chicago, Ill.
- Jan. 18—Mid-Winter Convention in Ophthalmology and Otolaryngology, Statler-Hilton Hotel, Los Angeles, Calif.
- Jan. 21-24—American Group Psychotherapy Association, Roosevelt Hotel, New Orleans, La.
- Jan. 22—Interspecialty Committee, AMA Headquarters, Chicago, Ill.
- Jan. 23-24—Council on Mental Health, Drake Hotel, Chicago, Ill.
- Jan. 24-25—Committee on Transfusion and Transplantation, Pier 66, Fort Lauderdale, Fla.
- Jan. 30-Feb. 1—Southern Radiological Conference, Grand Hotel, Point Clear, Ala.

- Jan. 31-Feb. 1—Midwinter Radiological Conference, International Hotel, Los Angeles, Calif.
- Feb. 1-3—Residency Review Committee in Internal Medicine, Ramada Inn, Tucson, Ariz.
- Feb. 7—Society of Teachers of Family Medicine, Palmer House, Chicago, Ill.
- Feb. 7-8—Council on Medical Service, Drake Hotel, Chicago, Ill.
- Feb. 7-14—College of American Pathologists, Shamrock Hilton, Houston, Tex.
- Feb. 8-9—Annual Congress on Medical Education, Palmer House, Chicago, Ill.
- Feb. 14-17—Joint Committee on Health Problems in Education of the National Education Association and the American Medical Association, Washington, D.C.
- Feb. 14-18—American Academy of Allergy, Jung Hotel, New Orleans, La.
- Feb. 15—Committee on Alcoholism and Drug Dependence, Washington, D.C.
- Feb. 20-22—Symposium on Rheumatic Diseases, Kachina Lodge, Taos, N.M.
- Feb. 25-March 1—American College of Cardiology, Rivergate, New Orleans, La.
- Feb. 27-March 1—AMA-AMPAC Public Affairs Workshop, Sheraton-Park Hotel, Washington, D.C.
- March 6-8—Committee on Nursing with its Panel of Nurse Consultants, Ponte Vedra Club, Ponte Vedra, Fla.
- March 8-10—American Association of Pathologists and Bacteriologists, Chase-Park Plaza Hotel, St. Louis, Mo.
- March 12—Council on Mental Health, Drake Hotel, Chicago, Ill.
- March 12-14—Southern Society of Anesthesiologists, Williamsburg Lodge, Williamsburg, Va.
- March 13-15—Council on Legislative Activities, Washington, D.C.

Medical Aspects of Community Fallout Shelter Confinement

JOHN A. HAMMES,* Ph.D., MARY P. BEUSSEE,† M.S.,
and THOMAS R. AHEARN,‡ Ed.D., Athens

Medical complaints and the adequacy of federally stocked medical kits have been evaluated in seven large-group community fallout shelter occupancy studies conducted by the Civil Defense Research Staff of the University of Georgia, involving a total population of 3,360 persons.

Four categories of complaints predominated throughout the studies—headaches, stomachaches and/or nau-

sea, cuts, abrasions or superficial infections, and colds or sore throats. Female shelterees registered more complaints than did male shelterees. All studies were conducted during the summer months, and results cannot be extrapolated to winter conditions.

A wide range of additional medical supplies was recommended by 15 physicians who took part in the tests.

THE CIVIL DEFENSE RESEARCH STAFF (CDR) of the University of Georgia conducted 12 simulated community fallout shelter occupancy tests during the period 1962-67. Men, women, and children, aged 6 months-79 years, participated in numbers of 30-1,000, for confinement periods ranging in duration from one day to two weeks. The last seven

tests involved large groups of shelterees, in numbers from 160-1,000 persons (Experimental Studies VI-XII, hereafter referred to as ES VI-XII), and were conducted during summer months (Tables 1 and 2).

Physicians and nurses were present in all tests for the purpose of providing emergency and rou-

TABLE 1
SHELTEREE AND SHELTER ENVIRONMENT VARIABLES
(ES VI-XII)

Experimental Study	Date	N	Shelterees		Defec- tions	Net Space/ Person		Shelter Environment		Ventilation cfm/person
			Sex	Age		sq. ft.	cu. ft.	Temp.	Hum.	
ES VI	31 July-2 August 1964	300	Men, women, children	3-66	0	10 ^a	—	opt.	opt.	Ventilation tests
ES VII	19-26 June 1965	307	Men, women, children	2-67	62	10 ^a	—	warm	mod.	Natural plus window fans
ES VIII	10-12 Sept. 1965	321	Men, women, children	1-67	8	10 ^a	—	warm	mod.	Natural plus window fans
ES IX	29 April-1 May 1966	160	Men, women, children	1-65	22	6-7 ^a	—	warm	mod.	Natural plus window fans
ES X	22-24 July 1966	504	Men, women, children	9 (mos.)- 73	87	8 ^a	—	warm	mod.	Window fans and VK ^b
ES XI	16-18 June 1967	722	Men, women, children	6 (mos.)- 79	82	10 ^a	—	warm	mod.	Window fans and VK ^b
ES XII	26-27 August 1967	1,046	Men, women, children	7 (mos.)- 77	48	10 ^a	—	warm	mod.	Building fans and VK ^b

^a Including storage.
^b OCD ventilation kit.

* Professor of Psychology and Director, Civil Defense Research.
† Research Assistant, Civil Defense Research.
‡ Associate Director, Civil Defense Research.

TABLE 2
SHELTER SUPPLY VARIABLES
(ES VI-XII)

Experimental Study ^a	Date	Water qt./person/day Consumed	Food cal./person/day Consumed	Shelter Supplies					Cig.	Recreational Supplies
				Sanitation	Bunks	Blankets	Bath Water	Coffee		
ES VI	31 July- 2 August 1964	1.0	306 cal. Nebraska cracker + 208 cal. carbohydrate supplement = 514 cal.	Chemical toilet	No	No	No	No	1 pk.	No
ES VII	19-26 June 1965	1.2 ^a	776 cal. ^a Cracker and carbohydrate supplement	Chemical toilet	Cots, sleep mattresses, and blankets ^b	No	No	No ^c	Yes	Yes ^b
ES VIII	10-12 Sept. 1965	.8 ^a	655 cal. ^a Cracker and carbohydrate supplement	Chemical toilet	Cots, sleep mattresses, and blankets ^b	No	No	No ^c	Yes	Yes ^b
ES IX	29 April- 1 May 1966	2.7 ^a	560 cal. ^a Cracker and carbohydrate supplement	Chemical toilet	Sleep mattresses and blankets ^b	No	No	No ^c	Yes	Yes ^b
ES X	22-24 July 1966	1.4 ^a	568 cal. ^a Cracker and carbohydrate supplement	Chemical toilet	Sleep mattresses and blankets ^{b, d}	No	No	No ^c	Yes	Yes ^b
ES XI	16-18 June 1967	1.3 ^a	358 cal. ^a Cracker and carbohydrate supplement	Chemical toilet	Sleep mattresses and blankets ^b	No	No	No ^c	Yes	Yes ^b
ES XII	26-27 August 1967	.8 ^a	551 cal. ^a Cracker and carbohydrate supplement	Chemical toilet	Sleep mattresses and blankets ^b	No	No	No ^c	Yes	Yes ^b

^a OCD stocked supply consumption. Amount of food and water brought in by shelterees not inventoried.

^b Not brought by all shelterees.

^c Brought by very few shelterees.

^d One cot provided in CDR supplementary medical supplies.

tine medical care, as well as for the experimental purpose of evaluating the adequacy of the federally stocked Medical Kit C for large-group fallout shelter use. The present report presents a summary of medical complaints occurring during shelter confinement, as well as an evaluation of shelter medi-

cal supplies. ES VI was the only air-conditioned test. All others utilized window exhaust fans.

Medical Complaints

The nature of medical complaints registered during ES VI-XII is indicated in Table 3. These data are based on medical complaint and treatment records maintained by in-shelter physicians; however, since medical personnel were not the same in all

TABLE 3
MEDICAL COMPLAINTS OF CDR OCCUPANCY STUDIES
(ES VI-XII)

Complaint	160-Person Study		300-Person Study				500-1,000 Person Study			Total
	ES IX ^a	ES VI ^a	ES VII ^b	ES VIII ^a	ES X ^a	ES XI ^a	ES XII ^c			
	N = 160	N = 300	N = 307	N = 321	N = 504	N = 722	N = 1,046			
Headache	58	157	208	54	94	38	32	641		
Stomachache, nausea	3	42	53	7	18	15	4	142		
Cuts, abrasions, infections	4	2	68	13	24	16	15	142		
Cold, sore throat	6	4	97	5	19	7	—	138		
Insomnia	—	—	42	1	22	—	—	65		
Body aches	—	2	11	4	5	8	—	30		
Constipation	—	—	23	—	—	—	—	23		
Earache, toothache	—	—	16	2	5	1	—	24		
Fainting, dehydration	—	—	5	1	16	1	—	22		
Miscellaneous (nervousness, diarrhea, allergic reactions)	4	9	28	6	14	24	11	96		

^a 48-hour confinement.
^b One-week confinement.
^c 24-hour confinement.

TABLE 4
MEDICAL COMPLAINTS BY SEX
(ES VI-XII)

Complaint	160-Person Study		300-Person Study						500-1,000-Person Study						Total ^d	
	ES IX ^a		ES VI ^a		ES VII ^b		ES VIII ^a		ES X ^a		ES XI ^a		ES XII ^c		M	F
	N = 160		N = 300		N = 307		N = 321		N = 504		N = 722		N = 1,046			
	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F
Headache	24	34	60	97	100	108	23	31	29	65	7	31	10	22	253	388
Stomachache, nausea	—	3	15	27	13	40	2	5	7	11	1	14	2	2	40	102
Cuts, abrasions, infections	3	1	1	1	13	55	9	4	9	15	7	9	11	4	53	89
Cold, sore throat ...	4	2	2	2	45	52	4	1	8	11	3	4	—	—	66	72
Insomnia	—	—	—	—	24	18	1	—	8	14	—	—	—	—	33	32
Body aches	—	—	—	2	2	9	—	4	—	5	4	4	—	—	6	24
Constipation	—	—	—	—	15	8	—	—	—	—	—	—	—	—	15	8
Earache, toothache .	—	—	—	—	8	8	1	1	—	5	1	—	—	—	10	14
Fainting, dehydration	—	—	—	—	2	3	—	—	4	12	—	1	—	—	6	16
Miscellaneous (nervousness, diarrhea, allergic reactions)	2	2	3	6	14	14	—	6	5	9	11	13	5	6	40	56

^a 48-hour confinement.
^b One-week confinement.
^c 24-hour confinement.
^d Taking into account proportional representation in the shelter population, female complaints were significantly higher than male complaints (Chi-Square = 14.007, P = < .001).

studies, medical records reflect differences in physician judgment of complaints. Four categories of complaints predominated throughout the studies—headaches, stomachaches or nausea, cuts, abrasions or infections, and colds or sore throats. Table 4 shows that female shelterees registered more complaints than did male shelterees.

Medical Supplies

One Office of Civil Defense Medical Kit C was utilized in all seven studies with the exception of ES X in which two were stocked. Medical Kit C components are listed in Table 5. In addition to Medical Kit C, the physicians in ES VI-VIII brought personal medical bags into the shelter, and

on the basis of in-shelter physician and nurse recommendations, supplements were added to Medical Kit C in ES IX-XII. Certain supplementary items were kept in a locked medical box in an emergency area outside of the shelter. The supplementary medical items are listed in Table 6. Since medical personnel were not the same in all studies, differences in medical evaluations of the stocked medical supplies are to be expected, and were obtained for Office of Civil Defense evaluation.*

The medics in ES VIII stated that the kit was only satisfactory for a limited number of minor complaints. It is interesting to note that the two other studies in which medics felt the kit inadequate were

TABLE 6
CDR SUPPLEMENTARY MEDICAL KIT PROVISIONS
(ES IX-XII)

Item	ES IX	Amount Stocked		ES XII
		ES X	ES XI	
Adhesive tape				
2" X 5 yds.	1 roll	1 roll	1 roll	7 rolls
1/2" X 10 yds.	3 rolls	same	same	same
Ammonia, aromatic	1 box	1 box	—	9 caps.
Aqueous Zephiran, 8 fl. oz.	—	1 btl.	1 btl.	1 btl.
Artificial respiration tubes:				
Adult	2	same	same	same
Child	2	same	same	same
Band-Aids, 56 assorted	3 boxes	same	same	same
Band-Aids, small	—	—	—	1 box
Basin, plastic	—	1	—	—
Benadryl, 25 mg.	1 btl.	1 btl.	50 tabs.	50 tabs.
Benadryl Elixir	4 btls.	4 btls.	3 btls.	2 btls.
Benylin Expectorant	2 btls.	6 btls.	6 btls.	6 btls.
Blanket	—	—	2	2
Cot, aluminum folding	1	1	—	1
Cough medication—Sudafed 4 oz.	—	8 btls.	7 btls.	6 btls.
Cups, folding paper, medicine 1 oz.	1 box	1 box	47 cups	131 cups
Cups, drinking	—	—	—	35 cups
Cups, non-folding, medicine	—	—	—	103 cups
Dextran, 6% w/v in dextrose, 5%, 500 ml.	1 btl.	same	same	same
Dextrose, 5% in H ₂ O, 1000 ml.	1 btl.	same	same	same
Dramamine	12 tabs.	same	same	same
Ephedrine Sulphate Injection, 1 ml.	2 pkgs.	same	same	same
Epinephrine Injection, 1 fl. oz., 1:1000	1 vial	same	same	same
Forceps, small tip	1	1	3	1
Furacin Soluble Dressing, 38 gms.	—	—	12 vials	—
Furacin Soluble Dressing, 28 gms.	3 tubes	3 tubes	—	3 tubes
IV Tubing (solution administrative set) 20 g. X 1 (1/2"), vein needle	—	3 sets	same	same
Milk, powdered	1 pkg.	1 pkg.	—	1 pkg.
Morphine, 30 cc., 16.2 mg./cc.	1 vial	same	same	same
Notebook, looseleaf	1	1	—	1
Oxygen, unit	—	1	—	1
Phenobarbital, sodium (12 ampoules/pkg.)	—	2 pkgs.	2 pkgs.	2 pkgs.
Salt, 1000 tabs./btl.	—	.5 btl.	.5 btl.	.5 btl.
Sodium Chloride Injection, 1000 ml.	1 btl.	same	same	same
Storable light (flashlight and 2 batteries)	—	1	1	1
String, 250 feet	—	1 roll	1 roll	1 roll
Sugar, cubed, 1 lb.	—	1 box	—	—
Syringes:				
Plastic, 2 1/2 cc., 25 g.	15	same	same	same
Plastic, 22 g.	6	same	same	same
Thermometer container, plastic	2	2	7	3
Thermometer, oral	3	3	6	3
Thermometer, anal	—	—	—	2
Tourniquet	—	1	1	1

the largest studies, composed of 722 persons (ES XI) and 1,046 persons (ES XII).^a Consequently, medical personnel were asked to list medications and supplies they felt would be valuable additions to the stocked medical kit. These recommendations are presented in Tables 7 and 8.

Obviously, some of the recommended items would be impractical or impossible to stock routinely in public shelters. They should be considered, therefore, as items to be kept in mind by local civil defense officials as additional supplies that should be stocked if a nuclear emergency threatened.

Summary

Medical complaints and the adequacy of federal-ly stocked medical kits have been evaluated in seven large-group community fallout shelter occu-pancy studies conducted by the Civil Defense Re-search Staff of the University of Georgia. Shelteree reaction and in-shelter physician assessment are presented in this report.

University of Georgia

TABLE 5
MEDICAL KIT C COMPONENTS
(ES VI-XII)

Item	Stocked
Applicator, wood, cotton-tipped end, 1/2" x 6"/100s	6 pkgs.
Aspirin tablets, 5 gr./1000s	3 btl.
Bandage, gauze, roller, 2" x 6 yds./12s	6 boxes
Bandage, muslin, compressed, camouflaged 37" x 37" x 52"	6 units
Cascara Sagrada Extract tablets, 4 gr./100s	6 btl.
Cotton, purified, 1 lb.	3 pkgs.
Depressor, tongue, wood, 100s	3 pkgs.
Eugenol, 1 oz.	1 btl.
Eye and nose drops, 1/2 fl. oz.	18 pkgs.
Forceps, dressing 3 1/2"	1
Isopropyl Alcohol	6 cans
Kaolin and Pectin Mixture	16 btl.
Pad, gauze, surgical 4" x 4"/200s	6 pkgs.
Penicillin G tablets, 100s	12 btl.
Petroleum, white, 1 lb.	3 cans
Phenobarbital tablets 1/2 gr./1000s	3 btl.
Pin, safety 1 1/2"/12s	12 pkgs.
Publication: "Medical Care in Shelters"	1
Scissors	3 pairs
Soap, surgical, 5% hexachl., 1 3/4 oz.	36 cakes
Sodium bicarbonate, 1 lb.	2 btl.
Sodium chloride, 1 lb.	2 btl.
Sulfadiazine tablets, 7 1/2 gr./1000s	3 btl.
Syringe, fountain	1
Thermometer, clinical, human, oral	4
Water purification tablets, iodine 8 mg.	12 btl.

TABLE 7
MEDICATIONS SUGGESTED BY MEDICAL PERSONNEL FOR
ADDITION TO SHELTER MEDICAL KITS
(ES VI-XII)

Medications	ES VI	ES VII	ES VIII	ES IX	ES X	ES XI	ES XII
Antiemetic	x	x	x			x	
Analgesics			x	x		x	
Stimulants for asthmatic or cardiac conditions	x	x	x				
Antiseptic		x	x			x	
Antibiotics ^a					x		x
Cough medication		x	x				
Sedative	x		x				
Nausea drug						x	x
Tetanus toxoid			x		x		
Ammonia		x					
Antacid or anticholinergic		x					
Antispasmodic		x					
Oxygen			x				
Phenobarbital, elixir					x		
Tranquilizers					x		
Dramamine						x	
Burn medication			x				
Plasma, blood volume expander, IV fluid			x				
Antitussives						x	

^a Antibiotics in addition to those stocked in Medical Kit C.

TABLE 8
SUPPLIES SUGGESTED BY MEDICAL PERSONNEL FOR
ADDITION TO SHELTER MEDICAL KITS
(ES VI-XII)

Supplies	ES VI	ES VII	ES VIII	ES IX ^a	ES X ^a	ES XI ^a	ES XII ^a
Band-aids, adhesive tape	x	x	x		x ^b	x ^b	x ^b
Thermometers and containers		x ^b	x ^b	x ^b			
Cups, folding paper		x	x			x	
Splints		x		x	x		
Airways		x	x				
Cleansing agent		x		x			
Childbirth kit				x	x		
Soap, liquid antibacterial	x					x	
Cot			x				
Flashlight				x			
Forceps, small tipped		x					
Infant supplies					x		
Medicine cup				x			
Milk, powered			x				
Needles, disposable			x				
Notebook, looseleaf		x					
Paper towels				x			
Basin			x				
Stretcher					x		
String				x			
Sugar, cubes				x			
Syringes, disposable				x			
Tourniquet				x			

^a Kits were supplemented with recommended items for these studies.

^b In addition to those items stocked in Medical Kit C.

* The purpose and limitations of the fallout shelter medical kit in the Federal Civil Defense Guide are as follows: "The objective in furnishing the kits is to provide a capability for serving the emergency needs of generally normal, healthy people. Medications are provided for preventing disease or limiting its transmission, for treating disease symptom to alleviate suffering and avoid complications, and for controlling emotional stress. Medications and devices requiring a high degree of professional competence and those intended for the treat-

ment of mass casualties caused by heat and blast effects are not provided. In overall civilian defense measures, treatment of casualties would come under a separate program from the shelter provisioning discussed in this appendix." (Part D. Ch. 2, App. 8, July 1967, p. 1)

This research was carried out under Contract No. DAHC 20-68-C-0114, Office of Civil Defense, Department of Defense, awarded to the University of Georgia. Project Director: J. A. Hammes.

The authors wish to express their appreciation to Robert A. Hatcher, M.D., for his participation in two of the occupancy tests, and for his helpful criticism of this article.

TWELFTH ANNUAL OFFICERS LEADERSHIP CONFERENCE

The Twelfth Annual Officers Leadership Conference will be held in Atlanta at the Sheraton Biltmore Hotel on February 14-15, 1970.

The Committee on Public Service has put together a most informative program which deserves your attendance as an officer in your local medical society. A few of the highlights are:

- ... A panel discussion on County Society Officers Responsibilities
- ... The services County Societies can receive from AMA, MAG and AAMA
- ... MAG Programs, Policies and House of Delegates Actions
- ... The County Society and Government Programs:

- Areawide Health Planning, Georgia Regional Medical Program, Medicare and Medicaid
- ... Future County Society Programs
- ... A Famous Athlete's Remarks
- ... PLUS ... "Ruby Red's Gay Nineties Band" who will provide foot tapping music during the Social Hour

Please make your plans **now** to be present. If you are not an officer in your county medical society, please pass this message along to the proper person. *It is important that your society be represented.*

A printed program will be mailed after the first of the year. Remember, this conference is where you learn how to better serve your county medical society. Please be present or send a representative.

The fetal mortality rate in this rare condition is very high.

Monoamniotic Uterine Twin Pregnancy

RICHARD TORPIN, M.D., and BARBARA POWELL, M.D., *Augusta*

THE RARITY OF monoamniotic twin pregnancy probably warrants a case report. For the fetuses it is a serious clinical entity (as in this instance) since two-thirds of them die by mutual twisting and knotting of their umbilical cords.

The patient attended by one of us (B. P.) was a Negro unwed girl, 15 years old; height, 5 feet 9 inches and weighing 219 pounds. She was first seen at about six months of pregnancy. Her blood pressure was somewhat elevated, 150/110 as it still was a month after delivery. Both of her parents had hypertension. She previously had been treated for hyperthyroidism and her menstrual periods had been irregular. Anemia was not present and the results of other examinations, urine et cetera, were normal. She had no obvious edema.

At about seven and one-half months of pregnancy a diagnosis of twins was suspected from the distribution and character of the fetal heart tones heard. Subsequently this was confirmed by radiography. About two weeks later fetal movements were no longer felt by the patient and fetal heart tones were absent. Thereafter she lost some weight and two weeks later she went into rather rapid labor and was delivered, spontaneously, of macerated male twins. The first one, weighing 3 pounds, was from cephalic presentation and the second one weighing 2 pounds was from breech. The placenta was expelled soon thereafter.

Figure 1 shows well the situation as to the umbilical cords which arose side by side from near the center of the normal discoid placenta. Illustrated are the twisting, knotting and venous engorgement quite common to intrauterine monoamniotic twins. The placenta, 17 cm in diameter, weighed 653 gm and is illustrated in figure 2.

Since both umbilical cords were equally distended death probably came to both fetuses simultaneously. Each umbilical cord, about 45 cm long, had the normal two arteries and one vein, the latter in each case considerably distended. No known facts can account for the unequal size of the fetuses.



FIGURE 1

Photograph of the macerated twins and placenta. This shows the knotting and twisting of the umbilical cords causing constriction fatal to the fetuses, as is common to two-thirds of the recorded cases.

Examination of the placenta and fetal sac which was intact except for the cervical rent demonstrated that there was only one amnion enclosing both fetuses, and there was no evidence that more than one ever existed. Radiopaque solution was injected into the distended vein of one umbilical cord. Subsequent radiography showed that the material had extended into the vein of the other umbilical cord; thus proving wide anastomosis of the two fetal circulations.



FIGURE 2

Photograph of the normal discoid placenta and the central common origin of the two umbilical cords.

Literature Review

Quigley (1935) made a collective review of the literature and with a case of his own found 109

authentic instances reported. There was a 68 per cent fetal mortality almost entirely due to knotting and twisting of the umbilical cords.

Raphael (1961) reported that, at Providence Lying-In Hospital, there was one set of monoamniotic twins for every 16,000 deliveries and one set of such twins to every 165 twin deliveries. He pointed out, however, that there is marked variation in the reported incidence ranging from one per thousand deliveries to one per 93,734. He added five new cases to those previously recorded making in all 183 cases. The fetal mortality was very high. Only 51 instances were accompanied by survival of both infants.

Benirschke and Driscoll (1967) in their *Pathology of the Human Placenta* incorporate an excellent discussion of monoamniotic twin pregnancies, and on page 100 present an illustration of a placenta almost identical to the one herein described.

Most of the authors cited have stated that Alfieri (Milan, 1903) was one of the first to make a collective review, compiled of 71 cases.

Medical College of Georgia

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THIRTY-THIRD ANNUAL MEETING THE NEW ORLEANS GRADUATE MEDICAL ASSEMBLY

The thirty-third annual meeting of The New Orleans Graduate Medical Assembly will be held March 2-5, 1970, headquarters at The Roosevelt Hotel.

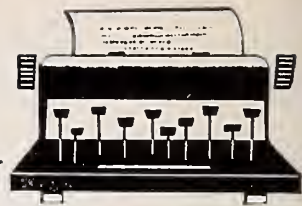
Nineteen outstanding guest speakers will participate and their presentations will be of interest to both specialists and general practitioners. The program will include 50 informative discussions on many topics of current medical interest, in addition to a clinicopathologic conference, symposia, medical motion pictures, round-table luncheons, and technical exhibits. This program is acceptable for twenty-two (22) prescribed hours and nine (9) elective hours by the American Academy

of General Practice.

An interesting and enjoyable program of entertainment for visiting ladies has also been planned.

Of special interest will be a one-day pre-Assembly symposium scheduled for Sunday, March 1 on "The Price of Medical Progress" presented by noted authorities. This symposium is acceptable for six (6) prescribed hours by the American Academy of General Practice. This session will be strictly limited to physicians and their wives.

For further information, contact Secretary, Room 1538, 1430 Tulane Avenue, New Orleans, La. 70112.



Vasculitis

THE GENERAL SUBJECT OF inflammatory vascular disease or vasculitis has remained unfathomable to the clinician. In the skin, where vasculitis is most commonly seen, inflammatory changes in and around blood vessels can be represented clinically by a spectrum ranging from hives all the way to polyarteritis—in short, the histopathology just does not relate to the clinical expression in many instances. Intense histologic vasculitis may be associated with benign, almost transient clinical courses, while focal, unimpressive histopathology may be found in severe illnesses. We are, therefore, often attempting to understand, diagnose, and treat a group of illnesses without the basic information on which we can rely.

It is beyond argument that medicine is becoming more and more indebted to molecular biology for descriptions of biological events at the cellular level. Inflammation, characterized for years by redness, heat, swelling, and pain, is now being understood in terms of the activation of the complement system, the clotting system, the kinin system, and lysosomal enzymes—all presently being studied in detail. Vasculitis, in turn, must be subjected to intense investigation.

Since allergic phenomena are currently thought to be related in some way to vasculitis, I thought it would be interesting to review some of the instances where allergic mechanisms have been related to inflammatory vascular disease, clinically or experimentally. Allergic mechanisms have been classified into the following groups:

Cytotoxic	Granulomatous
Inactivation	Arthus
Atopy	Delayed allergy

or, to make is easy to remember—C I A G A D, which does not represent any political criticism.

Cytotoxic reactions occur when an antibody is formed against certain types of cells and the reaction between antibody and cell results in cell death or change as, for example, in hemolytic anemia. Vasculitis appears in vascular purpura in which an allergic reaction may be directed towards the vascular endothelium. Experimentally, vasculitis can be produced by the injection of antibodies against vascular endothelium.

Inactivation Occurs

Inactivation may occur if an antibody is formed to an enzyme, hormone, or other cellular (or humoral) material; and, reaction between the two results in biologic inactivation or modification. No vasculitis has been shown to result from this type of reaction.

Atopy refers to the situation in which antigen, say ragweed pollen, becomes associated with certain cells that have been “sensitized,” or bound with antibody specific for that antigen. As a result, biochemically active substances are released which can mediate the allergic reaction (hay fever in our example). Cutaneous vasculitis probably does occur on an atopic basis and with the isolation of Ig G, the antibody thought to be commonly associated with atopic reactions (bound to cells?), interesting information should be obtained.

Granulomatous reactions occur against known antigen complexes in tuberculosis and in sarcoid, where no discrete antigens are recognized. Intense vasculitis occurs in regional enteritis (Crohn's disease) and in Wegener's granulomatosis (arteritis, nephritis, and sinusitis).

The Arthus phenomenon occurs when aggregates of antigen-antibody complexes in the form of circulating precipitates lodge in various structures where allergic manifestations then begin because of their presence. Serum sickness has been intensively studied and the vasculitis (as well as the nephritis and arthritis) is definitely related to the presence of antigen-antibody complexes in blood vessel walls. Arthus reactions have been implicated in the pathogenesis of lupus nephritis, glomerulonephritis, and other "immune" disorders.

Delayed allergy depends on the aggregation of lymphocytes specifically "instructed" to start an inflammatory reaction against a particular antigen, such as in the tuberculin skin test. Vasculitis is an integral part of the inflammatory reaction of delayed allergy, as in biopsies of tuberculin reactions and in graft rejections.

In summary, five of the six mechanisms by which allergic phenomena can produce tissue alteration can also be shown to be associated, at least in some manner, to vasculitis. These associations may or may not have any relevance to the subject, but such speculations allow us to look at the whole problem with some sort of viewpoint while the answers are obtained in the laboratory.

Marvin Cohn, M.D.

National Service

THROUGH SOME CAREFUL CONCENTRATED WORK on the part of the Executive Committee of Council and a few others, the attention of the AMA Board of Trustees was drawn to the outstanding accomplishments of two MAG members. At the Board's October, 1969, meeting, Thomas N. Lumsden, M.D., Clarkesville, Chairman of MAG's Committee on Rural Health, was appointed to the AMA Council on Rural Health; and Fleming L. Jolley, M.D., Atlanta, Chairman of MAG's Committee on Traffic Safety, was appointed to AMA's Committee on Medical Aspects of Automotive Safety; both terms to begin January 1, 1970.

It is encouraging to note that AMA is beginning to turn toward Georgia to select individuals to guide the profession at the national level and equally encouraging to find that Georgians are willing to accept additional responsibilities when called on. Selection to a national leadership role indicates recognition of ability, and acceptance of those opportunities demonstrates that the dedication displayed by the individual is genuine. May the number of opportunities grow and the number who will answer those calls increase.

J. Frank Walker, M.D.

FRONTIERS OF MEDICINE 1970

Registrations are being accepted for Frontiers of Medicine 1970 to be held in Lakeland, Florida, February 18 through 20. The meeting, sponsored by the Lakeland Graduate Medical Assembly, has been approved by the American Academy of General Practice for 14 hours elective credit.

A wide range of current medical topics is offered by this year's Frontiers of Medicine program with an out-

standing guest faculty from throughout the United States.

Co-sponsors of the Frontiers meetings—which last year was highlighted by Drs. Christiaan Bernard and Denton Cooley—are the medical staffs of Winter Haven Hospital and Bartow Memorial Hospital.

Registration fee is \$100. For details, contact the Lakeland Graduate Medical Assembly, P.O. Box 2335, Lakeland, Florida 33830 (813 683-1636 or 683-2038).



NAKED CAME THE STRANGER

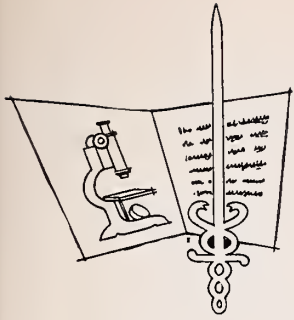
NOT TOO MANY MONTHS AGO there appeared on the shelves of the nation's bookstores a publication which immediately caught the public's eye and overnight mounted to near the top of the best seller lists. This book had a title which caught the eye of our country's thrill-seeking public and a cover jacket which caught not only the eye but the fancy of the people; the title was *Naked Came the Stranger*, and the jacket showed a picture of a curvaceous female stranger clothed just that way. In addition, a short synopsis of the book stated that it was the diary of a life-loving, love-loving Long Island housewife by the name of Penelope Ashe. Due to its appealing packaging and interest-arousing wrapping and subject matter, the book was an overnight success. It was not until later that it was discovered that the book was the work of some 24 hack writers, each of whom contributed a chapter, with no thread of continuity, no meeting of the minds or interest between one chapter and the next.

It seems almost as though the health programs in Washington were put together in the same fashion as were the chapters of this popular book. Those of us who have tried to work with these programs have long suspected the lack of cohesiveness between them. Now, to confirm our suspicions, along comes Senator Abraham Ribicoff, former Secretary of the Department of Health, Education and Welfare (who certainly should know whereof he speaks), and states that all Federal health programs are planless conglomerates. He is quoted as saying "There is little coordination among the 23 Federal Departments and Agencies that will spend \$18.3 billion on government health programs in 1970." But, by dressing up these programs with fancy words to make the citizens, voters and taxpayers think they are about to come on a windfall of all that is good, these programs are perpetuated and increased.

What's the answer? Perhaps the public wants to be duped into reading the fictitious diary of Penelope Ashe, thinking it the real thing. Perhaps the public is happy with a conglomerate of health programs put together like the chapters of *Naked Came the Stranger*, with no planning or programming from one chapter to the next. But, the public deserves better. We as physicians should continue our efforts to improve and better coordinate the programs of health care for the needy now in existence, and should present workable plans for whatever programs spring up in the future. Thus, our programmers will have the benefit of our knowledge as they seek ways to bring medical care to those who need it.

A handwritten signature in cursive script that reads "John Kirk Train".

John Kirk Train, M.D.
President, Medical Association of Georgia



THROMBOPHLEBITIS AND UNDERLYING CANCER

PANO A. LAMIS, M.D., *Atlanta*

A CENTURY AGO Trousseau first introduced the possible relationship between venous thrombosis and malignant tumors. In 1938 Sproul stimulated recent interest in this finding by his necropsy review from the Presbyterian Hospital in New York demonstrating apparent association. Numerous reports during the past three decades have supported the coexistence of these entities although the implication of this relationship for the clinician remained unsettled. A contrary writing from Duke University School of Medicine in 1957 was of the opinion that the incidence of venous thrombosis was no higher in people with cancer than in others with chronic debilitating disease. Nevertheless, these authors suggested that with idiopathic venous thromboembolism a diagnostic survey of a chest x-ray, three stool examinations for blood, and periodic followups was indicated.

Many reports strongly supported the association of thrombophlebitis and visceral cancer. A study at the New York Hospital-Cornell University Medical College reviewed 1,400 patients with venous thrombosis and found 81 of these patients had cancer. Thrombophlebitis in 31 patients was recognized prior to the diagnosis of cancer. The incidence of cancer complicating thrombophlebitis was 2.1 per cent to 3.0 per cent, a statistical conclusion that was similarly acknowledged in a review of 979 cases at the Boston City Hospital.

In a recent study, including only those cases in which the cancer was manifest subsequent to the recognition of thrombophlebitis, the authors concluded that the thrombophlebitis was often of the recurrent or migratory type and was frequently resistant to anticoagulant therapy. Of major importance they stressed that the development of thrombophlebitis did not preclude cure and in fact the onset of thrombophlebitis often facilitated early recognition and treatment of the neoplasm. This study, as have most of the others, supports the association of thrombophlebitis and malignant visceral neoplasms from many sites including the cervix, ovary, prostate, kidney, stomach, pancreas and lung.

An objective evaluation of the evidence presented in the medical literature does indeed suggest a relationship of thrombophlebitis and cancer. The physician should be cognizant of these facts and especially in the patient presenting with spontaneous thrombophlebitis or when the phlebitis is of the recurrent, migratory or anticoagulant resistant type. Any patient in this category should have a carefully taken medical history and complete physical examination including, in the female, a careful gynecological examination with a Papanicolaou test. Lab studies should include a complete blood count, urinalysis, examination of the stool for occult blood, and a chest x-ray. Complete x-ray studies of the entire gastrointestinal tract and kidneys may be indicated. Although several authors have advocated

exploration in the presence of normal blood studies, negative roentgenographic findings and thrombophlebitis, this decision must be individualized and based primarily on the doctor's concern that a cancerous lesion is being overlooked.

Louis Pasteur once wrote: "All things are hidden, obscure and debatable if the cause of the phenomena be unknown but everything is clear if this cause be known." These words aptly apply to the correlation of the entities, thrombophlebitis and cancer. The etiologic factors in this relationship have not been well defined, but most studies support an intravascular alteration, possibly an excessive release of thromboplastin due to cellular destruction. Once a definite cause of the phenomena of thrombophlebitis in association with malignant tumors has been delineated, the implications to the physician will similarly be well defined. In the interim, the clinician's index of suspicion must be the ultimate guide to the degree of evaluation for an undisclosed malignancy.

340 Boulevard, N.E.

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Announcing the Thirty-Third Annual Meeting of THE NEW ORLEANS GRADUATE MEDICAL ASSEMBLY

Conference Headquarters—The Roosevelt Hotel—March 2, 3, 4, 5, 1970

GUEST SPEAKERS

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Colon and Rectal Surgery
Walter B. Shelley, M.D., Philadelphia, Pa.
Dermatology
H. M. Pollard, M.D., Ann Arbor, Mich.
Gastroenterology
Walter Lane, M.D., Tampa, Fla.
General Practice
Henry Clay Frick, II, M.D., New York, N.Y.
Gynecology
William H. Crosby, Jr., M.D., Boston, Mass.
Internal Medicine
Thomas L. Petty, M.D., Denver, Colo.
Internal Medicine
David N. Danforth, M.D., Chicago, Ill.
Obstetrics

Jack A. Dillahun, M.D., Albuquerque, N.M.
Ophthalmology
John J. Niebauer, M.D., San Francisco, Calif.
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Omer E. Hagebusch, M.D., St. Louis, Mo.
Pathology
Chester M. Edelman, Jr., M.D., Bronx, N.Y.
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Howard P. Rome, M.D., Rochester, Minn.
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Wendell P. Stampfli, M.D., Denver, Colo.
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Surgery
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Surgery

Ralph A. Straffon, M.D., Cleveland, Ohio
Urology

Lectures, symposia, clinicopathologic conference, round-table luncheons, medical motion pictures, technical exhibits, and entertainment for visiting wives. (All-inclusive registration fee—\$35.00.)

This program is acceptable for twenty-two (22) prescribed hours and nine (9) elective hours by the American Academy of General Practice.

For information concerning the Assembly meeting write Secretary,
The New Orleans Graduate Medical Assembly, Room 1538,
1430 Tulane Avenue, New Orleans, Louisiana 70112.



THE INFANT WITH CYANOTIC CONGENITAL HEART DISEASE

GORDON M. FOLGER, JR., M.D., *Augusta*

OCCURRING ACUTELY OR SEMI-ACUTELY in the older individual, cyanosis is never regarded as anything less than an extremely pathologic condition and invariably demands and receives the most energetic of therapeutic measures. It is equally serious in the neonate and infant.

With the ready availability of refined diagnostic and surgical capability in most medical centers, the infant with congenital heart disease, irregardless of suspected severity, should not be denied any opportunity for survival and longevity. The infant with cyanotic congenital heart disease often represents a condition of the most severe nature and is at extreme risk if these capabilities are not offered early. When given optimum care, the most gratifying results may be obtained in many instances in such children.

The cyanotic newborn is often a large, healthy appearing infant, whose only obvious manifestation of illness is his cyanosis and perhaps, but by no means invariably, a cardiac murmur. In terms of disease, the cyanosis indicates marked reduction in systemic arterial oxygen saturation dependent somewhat on the hemoglobin level but always associated with an extremely pathologic condition. The cyanotic infant is not only manifesting severe disease by his cyanosis, but he is suffering dire consequences because of it. It is now well recognized that the hypoxia producing the cyanosis significantly causes reduced oxidative metabolism in these infants, giving rise to accumulation of lactic and pyruvic acid which may occur rapidly, resulting in metabolic acidosis of severe and often lethal magnitude. After this acidosis is recognized and corrected medically, then improvement of systemic oxygenation by surgical or at times cardiac catheterization techniques can be carried out and will often result in permanent alleviation of the problem. Frequently, the life of a child with a potentially correctable cardiac defect will have been preserved.

In cyanotic conditions, it cannot be overemphasized that temporizing serves no gainful end, because serious damage or death of the infant from severe hypoxia and acidosis is almost certain. Thus, the infant with cyanotic congenital heart disease should have cardiac catheterization as soon as he is discovered to be cyanotic, regardless of age and size. Prompt, definitive therapy then should be carried out as indicated by such study.

Medical College of Georgia

Prepared at the request of the Committee on Professional Education of the Georgia Heart Association.



STATUS OF EMERGENCY ROOM PRACTICE

JOHN L. MOORE, JR., *Atlanta**

IN SEPTEMBER, 1969, THE COURT OF APPEALS of Georgia issued an opinion in an important case involving the death of a patient at DeKalb General Hospital.

While the decision does not give any of the medical facts of the case, it does indicate that the patient died at the hospital. The family brought suit against the Hospital Authority of DeKalb County which owns and operates the hospital, alleging that the medical doctor who treated the patient in the emergency room was employed by the Authority, was negligent, and, therefore, that the Hospital Authority was negligent and liable to the patient's family.

The hospital moved for a summary judgment without a trial and provided evidence by way of an affidavit of the hospital's Administrator.

Relationship With the Hospital

The Administrator's affidavit attached a contract between the Hospital Authority and a partnership of physicians called the "DeKalb Emergency Group." The decision indicates that the contract obligated the partnership to provide certain professional services in the property of the Hospital Authority, specifically in operating the emergency room of the hospital on a 24-hour basis.

The agreement expressly designated the partnership as an independent contractor, meaning that it would be free to use its own judgment in providing professional services for patients through its various partners and medical employees. The agreement specified in detail the different duties assumed by the partnership and which patients would be treated by members of the partnership as distinguished from regular staff members of the hospital.

Decision

After carefully reviewing the form of the agreement, the Court of Appeals of Georgia held that the hospital did not have that degree of control over the professional services rendered by the partnership and its partners and employees to constitute "employment." Therefore, the Hospital Authority was not responsible for the allegedly negligent services of one of the partners or employees of the DeKalb Emergency Group. The Court pointed out that the agreement merely identified the work to be performed by the partnership and did not attempt to reserve control over the manner in which the services were to be performed. The agreement did provide that the services were to be performed in general to the satisfaction of the Authority and that the medical aspects of such treatment were subject to surveillance by the medical staff of the hospital in accordance with good medical practice. There were also provisions for administrative liaison between the partnership and the Authority. Either party to the agreement had the right to terminate it on six months' written notice.

* Prepared at the request of The Medical Association of Georgia. Mr. Moore is a member of the firm of Alston, Miller & Gaines, General Counsel to The Medical Association of Georgia.

The Court stated that the limited measure of control retained by the hospital did not amount to the exercise of control in the diagnosis or treatment of illness or injury. Therefore, the status of the partnership and each of its partners and employees was that of independent contractor and not that of employees of the Hospital Authority.

Comment

In recent years many hospitals have not been able to staff emergency rooms with residents and interns. As a result, the larger hospitals without a residency program have turned to full-time fully licensed physicians to perform emergency services in the emergency rooms of the hospitals. A number of hospitals in Georgia have entered into contracts with groups of fully licensed physicians to perform services in the emergency rooms for patients requiring such services who either do not have an admitting physician on the staff or in the period of time before the admitting physician can arrive at the hospital.

Obviously, from the point of view of liability of the hospital for services provided in the emergency room, it is desirable that the hospital not exercise control and employment of the physicians staffing the emergency room. Therefore, the reported decision is quite important to hospitals. In addition, from the physicians' point of view, it is important to emphasize that the relationship is that of an independent contractor and not of employment by a corporation. Both law and ethics of medical practice require this. The employment is between the particular patient and the physician, not between the Hospital Authority and the physician. Similarly, charges for services rendered to patients are normally made on a fee for service basis and the hospital is not financially interested in such fees.

As always, it is important that the decisions of the court coincide with the ethical and legal requirements as to the practice of medicine. Therefore, it is a pleasure for this writer to report on the recent decision of the Court of Appeals of Georgia. It is well written, clear, and prepared with apparent full knowledge of the actual practice which has now begun in various hospitals around the State.

Suite 1220
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* The case discussed is *Pogue v. Hospital Authority of DeKalb County*, Case No. 44473, Court of Appeals of Georgia, September, 1969.

MAG LEADERSHIP CONFERENCE

The Twelfth Annual MAG County Society Leadership Conference is scheduled for February 14-15, 1970, at the Sheraton Biltmore Hotel in Atlanta. The meeting will be held in the new Seminar Room.

The conference is planned as a working session to help County Society Presidents and Secretaries to better understand and execute their duties. There are segments of the program of interest to the MAG officers, committee chairmen and other guests.

Areas of emphasis will include: responsibilities of the County Society President and Secretary, ways a County Medical Society can be served by a local Executive Secretary, services a County Medical Society

can receive from MAG, AMA, and AAMA, MAG programs, policies and House of Delegates Actions. Other topics of interest include: Arcawide Health Planning, the Georgia Regional Medical Program, Medicare and Medicaid, the Effective Committee, Allied Health Personnel recruiting and Georgia's Disaster Plan.

There will also be a light side to the two-day conference. Saturday evening MAG will host a Social Hour for the physicians and their wives. Entertainment will be provided by "Ruby Red's Gay Nineties Band." Physicians are encouraged to bring their wives for a Valentine weekend in Atlanta.

THE ASSOCIATION



NEW MEMBERS

Black, Wiley S. Active—Hall—SU	194 Gold Street Gainesville, Georgia 30501
Christian, J. D., Jr. Active—Richmond—OR	1140 Druid Park Ave. Augusta, Georgia 30904
Cundey, Paul E., Jr. Active—Richmond—I	Medical College of Georgia Augusta, Georgia 30902
Handy, John R. Active—Richmond—I	1726 McAnally Street Augusta, Georgia 30904
Herrera, Pascual Active—Cobb—SU	644 Cherokee St., N. E. Marietta, Georgia 30060
McGraw, Walker C. Active—Hall—SU	700 S. Enota Dr., N. E. Gainesville, Georgia 30501
Oldham, Harry M., Jr. Active—Richmond— OBG	1501 Anthony Rd. Augusta, Georgia 30904
Strittmatter, James C. Active—Hall—R	Hall County Hospital Gainesville, Georgia 30501
Temple, T. E., Jr. Active—Richmond—I	Talmadge Memorial Hospital Augusta, Georgia 30902
Vaughan, William L. Active—Richmond—SU	VA Hospital Augusta, Georgia 30904
Williams, George P. Active—Richmond— OBG	1505 Winter Street Augusta, Georgia 30904

SOCIETIES

The Georgia Medical Society was one of the sponsors of a Health Careers booth at the Coastal Empire Fair in October. Cards provided individuals visiting the booth with the names and addresses of at least two schools, the length of the desired training, its cost and the availability of scholarships.

PERSONALS

First District

Jules Victor, Jr. spoke on "The Hidden Diabetic" at the October meeting of the Veterans of Evans County.

Second District

Charles B. Gillespie was inducted into fellowship of the American College of Surgeons at the organization's annual session in San Francisco in October.

Third District

Calvin Jackson was named to membership on the Georgia State Medical Board of Education in October by Governor Lester Maddox.

Fifth District

Brown W. Dennis is in charge of planning the first Layman's Institute of Cardio-Pulmonary Resuscitation. Sponsored by the Fulton County Medical Society, the seminar will be held January 19-21 at the Academy of Medicine.

Dixon A. Lackey, Jr., was named director of the medical care administration division of the State Health Department in October.

Bruce Logue participated in a symposium on Pericardial Disease at the University of Kentucky, in October.

Seventh District

Billy J. Davis moved his practice from Blairsville to Dalton in October.

Mark A. Gould was named to serve on the citizens' advisory panel to the State Health Department's Division of Mental Health in October.

Thomas S. Harbin has been elected to a three-year term on the Board of Trustees of the American Association of Ophthalmology.

Eighth District

George E. Mixon received a 15-year pin from the American Academy of General Practice at the organization's annual meeting in Philadelphia in October.

S. William Clark of Waycross has been elected to the House of Delegates of the American Association of Ophthalmology.

Tenth District

Clyde V. Tanner opened his practice in Martinez in October.

DEATHS

H. M. S. Adams

H. M. S. Adams died October 21 at his home in Atlanta. A general practitioner in Atlanta for 52 years, he was a graduate of the University of Georgia and Atlanta Medical College.

Dr. Adams was a member of the Fulton County Medical Society, the Medical Association of Georgia, and the Baptist Church.

He is survived by two daughters and a son.

Horace E. Crow

Horace E. Crow died September 30 at the age of 78.

A former medical staff member at Battey State Hospital, he served as acting director on two occasions. Dr. Crow joined the state tuberculosis hospital in 1931 when it was located at Alto and moved to Rome when facilities at Battey Hospital were released to the State in 1946.

Dr. Crow retired in 1961. Survivors include his widow and two sons, Horace, of Jacksonville, Fla., and Harold, of Athens, Ga.

Jarrett William Palmer

Jarrett William Palmer of Ailey died at his home October 23 after prolonged illness. He was 95.

A graduate of Baltimore Medical College, he was one of the organizers of the Association of Seaboard Railway Surgeons in 1903, and was appointed to the State Board of Medical Examiners in 1910, where he continued until 1966.

Dr. Palmer helped found Union Baptist Institute, now Brewton-Parker College in Mount Vernon, Ga., and was a member of its board of trustees for more than 50 years.

He was a member of the Ailey Baptist Church, president of the Georgia Medical Society in 1919-20, and member of the Medical Association of Georgia.

Dr. Palmer is survived by his widow, Mary Peterson Palmer; daughter, Mrs. Donald P. Moore Sr., Cowpens, S.C.; one grandson and a granddaughter.

GP'S HOLD 21ST ANNUAL SCIENTIFIC ASSEMBLY

The Georgia Academy of General Practice held its 21st Annual Scientific Assembly in Atlanta on November 7-8 and attracted its largest crowd in a number of years.

The non-scientific highlight of the two day meeting at the Marriott Motor Hotel was the convening of the first state-level Congress of Delegates, created by the adoption of a new GAGP Constitution and Bylaws. The Congress will become the highest policy making body of the Georgia Academy.

The faculty for the scientific program, well-attended by Family Practitioners from throughout the state, included six out-of-state guest speakers who lectured on industrial dermatoses; chronic and recurrent headaches; office management of smoking problems; abnormal GYN bleeding in older women; drug treatment for depression; and coronary artery diseases. A panel discussion between the guest speakers and the participants closed each day's program.

T. A. Sappington Installed as President

Topping off the traditional President's Banquet was the installation of T. A. Sappington, M.D., of Thomaston as President of the Georgia Academy for the 1969-70 year. Outgoing President, I. D. Hellenga, M.D., passed the gavel in a brief ceremony.

Other officers elected and installed were: President-Elect, R. D. Walter, M.D., of Calhoun; Vice President, George E. Mixon, M.D., of Ocilla; Secretary-Treasurer, Lyle Herrmann, M.D., of Hapeville. The Congress of Delegates elected Don Schmidt, M.D., of



T. A. Sappington, M.D. (left), accepts Presidential gavel from I. D. Hellenga, M.D.

Cedartown and J. C. Dismuke, M.D., of Adel as Speaker and Vice Speaker respectively to preside over future meetings of the governing body.

THE MONTH IN WASHINGTON

An American Medical Association spokesman outlined the AMA's voluntary national health insurance plan, "Medicredit," for consideration by the House Ways and Means Committee.

Dr. Russell B. Roth, speaker of the AMA's House of Delegates and a practicing physician in Erie, Pa., said the plan, which would be financed in part by federal income tax credits, is flexible and would assure all Americans—no matter how limited their financial resources—of adequate health care protection.

AMA Belief

"Representing this country's physicians as we do," Dr. Roth said, "the AMA is on record in its belief that it is the basic right of every citizen to have available to him good health care.

"Today we want to put before this committee a plan which is universal in scope, voluntary in nature, and realistic in terms of total program cost."

He estimated the program would cost the federal government \$8 billion to \$9 billion a year, but about \$3 billion a year of that would be offset by liquidation of the Medicaid program. Medicare would continue.

Free Protection

"For those in low-income categories, this protection is theirs without expense or contribution on their part," Dr. Roth said. "For those with moderate and higher levels of income, Medicredit provides a system of cash incentives to enable them to protect themselves against major health care costs. . . .

"Our proposal is the result of years of careful study of our existing mechanisms for delivering and financing health care, coupled with our close study of the federal government's ability to fund a universal health insurance program. . . .

"It would give to persons who have purchased comprehensive health insurance the option of receiving a tax credit on their annual federal income tax return, a credit based on their tax liability. That is, a taxpayer could take as a credit against the amount of income tax owed to the federal government, all or part of their personal cost for comprehensive health coverage. Persons or families with a lower tax liability (usually reflecting lower income or more dependents and allowable expenses) would receive a greater tax credit. And those families in the lower 30 per cent income range would, without cost to them, receive a certificate enabling them to purchase health coverage from qualified groups or plans."

The AMA plan calls for establishment of a "Health Insurance Advisory Board" to create Medicredit guidelines. It would be chaired by the Secretary of Health, Education, and Welfare and include the Commissioner of Internal Revenue and public members. It would review the effectiveness of the program and file annual reports with the President and the Congress.

Benefits of Medicredit

Basic medical benefits of Medicredit would include:

—Up to 60 days of inpatient hospital services, including maternity services;

—All emergency room and outpatient services provided in the hospital;

—All physicians' services, whether performed in the hospital, home, office or elsewhere.

Supplemental benefits to basic coverage would also be eligible for tax credits.

Dr. Roth stressed the importance of utilizing private insurance carriers, thus taking maximum advantage of private sector competition to help hold costs down.

The Hall Plan

Rep. Durward G. Hall, M.D. (R., Mo.), a former member of the AMA House of Delegates submitted to the committee another national health insurance plan. The first part of his two-part plan calls for the federal government to furnish persons eligible for Medicaid with health insurance certificates covering certain specified basic health protection. The states would have the responsibility for the balance of health care for an eligible individual after his basic coverage had been exhausted. Thus, the Hall plan would replace Medicaid.

The second part of the Hall proposal calls for the federal government helping, in cases of catastrophic illness, those persons who can afford normal health care insurance only.

Other national health insurance plans are being sponsored by Walter Reuther, head of the automobile workers' union; the AFL-CIO; Sen. Jacob K. Javits

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(R., N.Y.), and Gov. Nelson Rockefeller of New York. Indications are that the committee will not give serious consideration to such legislation before next year at the earliest. However, it appears probable that the issue will come to a vote in Congress before the 1972 elections.

AMA Statement

The AMA also submitted to the Ways and Means Committee a statement on the Nixon Administration's "Health Cost Effectiveness Amendments of 1969" legislation.

The AMA commended the Department of Health, Education and Welfare for its efforts to curtail the rising costs of Medicaid and Medicare, but said that the Association believes "there are better and more appropriate means of meeting this problem."

As for the provision prohibiting payment to physicians who have committed fraud, overcharged or otherwise abused the Medicare program, the AMA said:

"It should be kept in mind that there presently exist remedies to reach the cases of abuse which may exist—certainly the cases of extreme abuses which HEW has asserted these proposed penalties are intended to reach. While it is true that the law does not provide authority to disqualify physicians as to prospective participation, a carrier may reject or review a physician's claims on an individual basis as each claim is presented.

Changes in Administration

"The apparent concern of the Congress regarding alleged abuses and increasing program costs may require some changes in the administration of federally financed health care programs. However, the proposed amendments appear to introduce more severe remedies than the problems require."

As for the provision that utilization review commit-

tees pass retroactively on the medical necessity of admission of Medicare patients to hospitals, the AMA said:

"At the present time a utilization review plan of an institution must provide for review, on a sample basis or other basis, of admissions, duration of stays, and services furnished but must provide for review of each case of extended stay and also determine medical necessity of further stay. The law provides for three additional days of benefit payments after a negative finding and notification.

"Where a finding has been made that the admission was unnecessary, no payment would be made. Thus the denial of payment would be retroactive to the date of admissions. The three-day grace period is removed from existing law.

AMA Objection

"The AMA previously objected to initial certification of the need for admission to a hospital, and this initial certification requirement was removed from the law. Under this bill the utilization review committee would be required to review the attending physician's judgment as to the need for hospitalization. The present requirement of the committee under Medicare is to review extended stay cases to determine need for further stay; thus it does not review a great number of cases of hospitalization where the patient is discharged earlier. Requiring committees to review all cases of hospitalization would impose a tremendous burden on the committee, and create additional heavy demands on physicians' productive manhours.

"An adverse finding by a committee would subject the patient to individual liability for hospital charges. As a result, this provision could act as a restraint on patients receiving care, particularly in those cases where a physician recognizes the possibility of differing medical judgments concerning the admission."

GALLEY PROOF CORRECTIONS

There is sometimes a misunderstanding about changes in an article on the galley proofs and the reluctance of the JOURNAL to make extensive alterations. The reason for this is quite simple and easily understood when one knows all the facts. The article has already been set in type. To make extensive changes requires that the typesetting be done over, at an additional cost which may even exceed the original, because it is slower work to fit pieces together than to set an entire article in type. It is also obvious, when one stops to think about it, that an alteration in the first few lines of a paragraph will probably make it necessary to reset the entire paragraph. This, of course, increases greatly the cost of printing and should be avoided as much as possible. The galley proof is for correction of *errors*, and a rewriting of the article should be done on the original copy before it is submitted for publication.

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